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THE HOSPITAL WORLD

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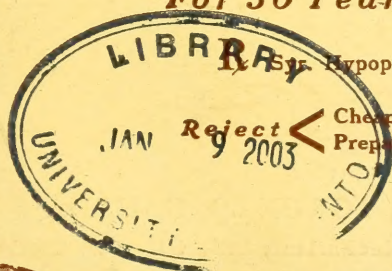
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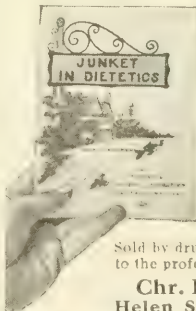
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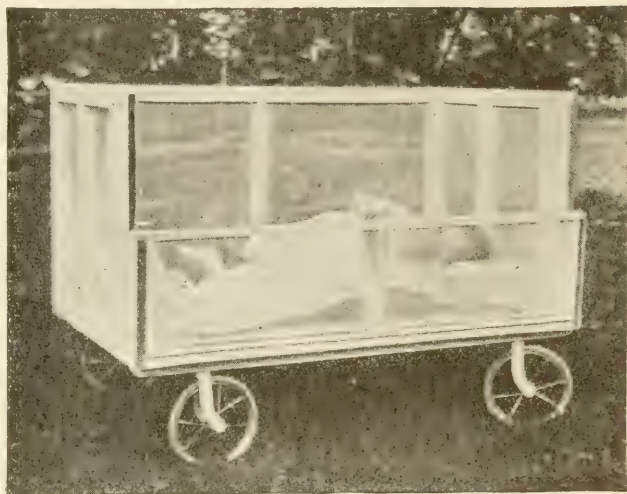
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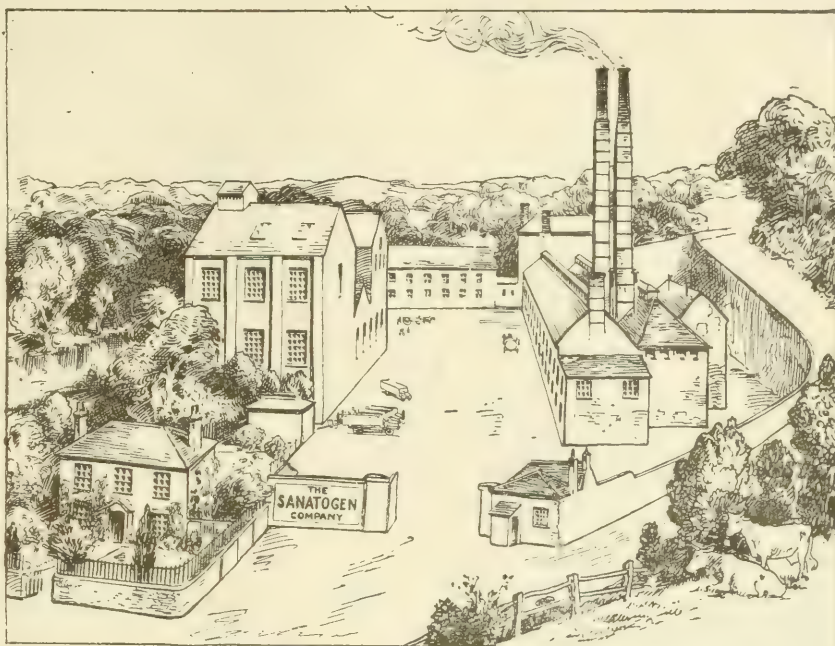
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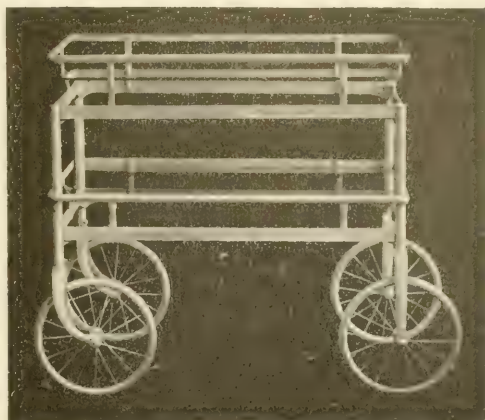
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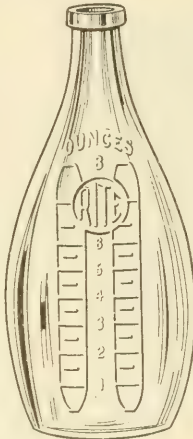
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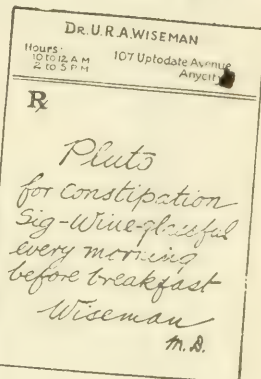
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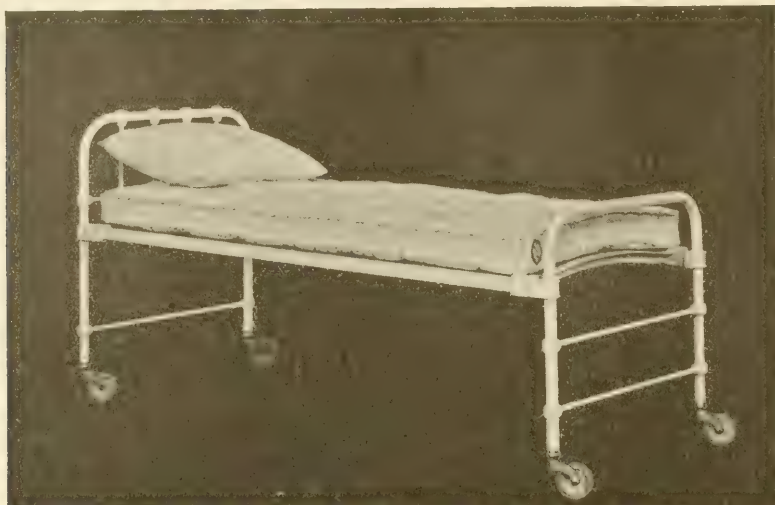
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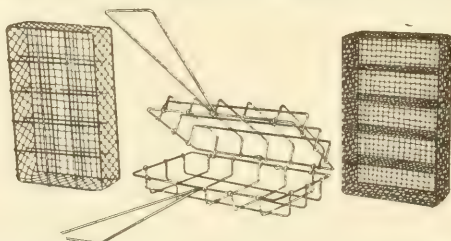
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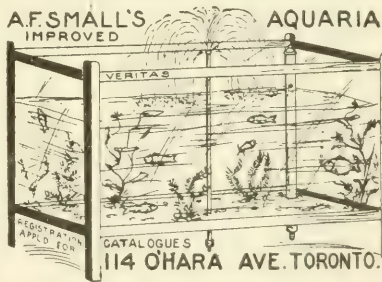
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Voi. X.

TORONTO, JULY, 1916

No. 1

Editorials

THE FOOD LABORATORY

THE word metabolism is at present much to the fore in medicine. Simply interpreted, it designates the science of food in its values and effects on the body

tissues. This science, through recent specialization and keen laboratory research, is making valuable contribution to the treatment of certain diseases.

Varieties of diet for infants, consumptives, patients suffering from liver and kidney diseases have been recognized and prescribed long enough to make a general knowledge of the same a common public possession. But this new realization of the absolutely definite and instant action of food constituents upon diseased organs is opening up a fresh avenue in therapeutics, and one giving far-reaching vistas.

The dietitian is lifted from the position at first assigned as head of a nurses' kitchenette for supplying and teaching the preparation of dainty and invalid foods. The office must now be filled by a scientifically trained investigator with a laboratory staff upon whose results the physician will depend to an extent and in detail unknown in the past.

A few hospital laboratories are making remarkable findings along this line of work, and as all our institutions are in close touch and quick to recognize progress, other hospitals will doubtless soon fall into rank.

The article by Miss McCullough on this subject in the May issue of the Journal of the Canadian Medical Association is a revelation of what one hospital is accomplishing in this direction. It indicates not only the high value of results achieved in furthering treatment of disease; but also incidentally shows how large a determining factor metabolism is

becoming in the science of medicine, and how important the laboratory devoted to its study must become in the hospital.

An even more valuable point made in the paper referred to was that of after care of metabolic cases who are leaving the hospital. The Peter Bent Brigham Hospital is planning to teach such patients simple methods by which they may test their condition, know when to fast, and what foods to drop for a time. The outdoor clinic in some of the large hospitals is carrying education still further in these directions by holding weekly diabetic clinics at which all discharged diabetics and other patients suffering from metabolic disorders are urged to attend for further instruction and treatment.

TEAM WORK

It is rather remarkable that, in this day of Capital combine, of unions, of teamwork in so many departments of service, the medical fraternity has remained so individualistic in its methods, and that there is yet so much of personal competition. Men of other professions—lawyers, architects and engineers—group in firms, each several member having his special phase of work.

But in medicine, while the general practitioner and the specialist both exist, each is but formally connected for professional purposes. Each “goes it alone” to an extent that keeps the unfortunate pa-

tient in the condition of the hospital inmate who had a broken leg. Later phlebitis developed in the remaining member. "Other leg swollen, you say," said the attending surgeon, as he manipulated the splints. "No, I won't look at it. That's not my leg. It belongs to Dr. Smith." And he adhered to his resolution.

This long prevailing custom of individualism in medicine seemed good and sufficient when all physicians, or nearly all, were what is termed all-round practitioners. But with the rapid advance of specialization its weaknesses have yearly become more evident, until to-day some degree of medical combine, union, group service—call it what we will—has become inevitable; and a new departure in this matter is already begun.

The Mayo Clinic at Rochester is perhaps the first and most excellent instance of medical team work. At this clinic every patient has the benefit of the combined diagnosis of a band of specialists at a charge based upon the income of the patient.

The Clinical Club of St. Luke's Hospital, San Francisco, organized about three years ago, is another noteworthy effort to establish medical team work on a satisfactory basis. This club of ten men examine the patient, make written report of their findings, and meet daily to discuss the case. If the results are not clear the patient who is in the hospital under observation is re-examined daily until some definite conclusion is reached. The physician who

first referred the case has then given to him—or mailed to him—the findings and recommendations of these specialists.

The fee collected, says one of the team, is not sufficient to pay for the time of the various clinicians, but the educational returns for each member in the daily discussion with his colleagues amply repays them.

The results of this or of some similar scheme of grouping is obvious even to the lay mind. It brings to both patient and physician all the advantages of specialism, without its clearly seen disadvantages. The patient has placed at his service, at a price within his means, the observations and conclusions of a group of specialists trained along many lines. The family physician has a strong reinforcing aid in his treatment of the case, while the specialist gains broader and contributing points of view.

Team work in medicine is fast arriving—and it comes to stay.

HOSPITAL AND HEALTH CENTRES

It is estimated that about ten per cent. of sick folk go to hospitals. Of the remaining ninety per cent. but a small proportion have specially skilled medical attendance or trained nursing. Fortunately, the average case of pneumonia, typhoid, influenza, scarlet fever will recover if the medical attendant but ob-

serves the first rule of therapeutics—*non nocere*. Let us say that three-quarters of the general practitioner's clientele consists of these uncomplicated cases which go on to recovery if no harmful medicaments are prescribed. There yet remains one-quarter of the cases which are more or less baffling. The patients in this class suffer from diseases that are not properly diagnosed; and the physician, too often, gives a shotgun prescription, with the hope that by chance it will afford relief. Of course, occasionally the remedy relieves the disorder. When it fails to do so the patient leaves the original doctor and goes first to one and then another, until the medical gypsy habit is well established, after which he is ready to try some patent medicine, spiritual healing, faith cure, or Christian Science.

Such patients, perhaps neurasthenic, possibly rheumatic or syphilitic, enrich the manufacturer of the proprietary nostrums, and by their conduct throw much stigma upon the medical profession.

To meet this breakdown in medical practice certain improvements are necessary. Among these are the abolition of the proprietary medical school; the better training of medical students at college, and a course of three years in resident hospital practise.

But the best provision may be found in very recent formation of hospital or health centres where the acute or chronic conditions of obscure disorders may be studied thoroughly.

These cases demand examination from the laboratory standpoint—chemical and bacteriological; careful and repeated physical examinations by the internist; probably a study by an ophthalmologist, oto-laryngologist, a neurologist, or psychiatrist. The health or hospital centre should have attached to it at least one of each of such specialists.

And the medical profession should be the vanguard in the establishment of such centres.

Original Contributions

A PLEA FOR THE TRAINING OF MEN AS NURSES

BY FRANK H. HOLT, M.D.,

Superintendent of the Michael Reese Hospital, Chicago, Formerly Assistant Superintendent of the Boston City Hospital, Boston.

I BELIEVE the time has come for Superintendents of General Hospitals and Superintendents of Training Schools to give their attention and serious consideration to the training of men as nurses. I am aware that here and there it has been tried and in some cases been discontinued.

Hospitals for the care of mental and insane patients have trained men on equal terms, in their schools, in the same classes with women, and their success can be gauged by a glance at their alumni roll, which shows the names of many men as graduates who afterwards attained distinction in the medical and allied professions, as well as in business. Why should not men, as well as women, care for the sick and injured, if they so desire, and why should they not be trained?

There is no question but what there has been a demand for this training the last few years.

For certain purposes the services of men are needed in every hospital—to transport patients, assist in handling helpless and delirious ones, give baths, do dressings and wait on the male patients.

In hospitals too small to employ men for ward work alone, such of the above duties as cannot be done by the female nurses are thrust upon the general utility man; in the larger ones, not only are they all performed by the men, but more—as the taking of temperatures, giving of medicines, and, in fact, everything that is done by the female nurses, but without the training or recognition given the latter.

For several years, while Assistant Superintendent of one of the largest general hospitals in the East, I had charge of seventy-

five men engaged in ward, accident and operating floor work, and the experience gained proved both interesting and instructive.

The training school for men was started in 1911; previous to that time the only training given was that transmitted by an older to a younger man on the ward and covered only such information as was actually necessary for the discharge of his daily work.

The men employed were required to fill out a blank form, composed of questions giving information about their past life, work, etc. Oftentimes some of the applicants were so ignorant as to be unable to fill it out in full correctly.

The class of men represented ranged from the trained graduate of an insane hospital training school or green country boy coming to the city to make his way, or to acquire an education, taking this position as a means of paying his way or as a step to something better—to the broken-down, unsuccessful graduate of medicine and "down and outer" from other lines of work, who had spent the previous night on a park bench and who wanted a "job."

Some of these men were drug or alcohol addicts, or were rolling stones of hospital life, and in spite of the most careful scrutiny would be accepted only to have their failing discovered afterwards.

At times it was impossible to get sufficient men to carry on the work properly—due to their restless and roving dispositions. To emphasize this and show the immense amount of work necessary to maintain the standard number, i.e., the 75 required, the following figures may be of interest. They represent the figures for eleven consecutive years.

Number of applications received.....	3,225
Number of applicants accepted.....	1,167
Number who came after acceptance.....	768
Number of graduates, i.e., those who remained the required two years and received a certificate or diploma.....	168

It is from such a class of men that general hospitals have had to draw for their male ward help. These men were known as orderlies, ward masters, ward tenders, etc.—any training being grudgingly given them, even if they were worthy to receive it.

When conditions became such that something had to be done a slight increase of wages was made—this in the hope of getting not only more, but a better class of men. At times these men were sufficiently interested to ask for some instructions in order to better their condition, but too often they were only looking for a bed, three meals and their weekly pay. It can be seen that but few of the better class of men would stay in the work, and the result was most discouraging for those in charge of them and no incentive to interest themselves in giving instruction.

The class of men who apply for hospital work can be broadly divided into four groups:

1. The graduate of an insane or other hospital who desires additional training in medical, surgical or contagious work.
2. The boy from the country coming to the city for work or an education, and taking this as a means of supporting himself until established, or as a stepping stone to something better later.
3. Men whose temperament is such that they prefer inside to outside work.
4. By far the greatest in number, men who for one reason or another have given up other lines of work and take this simply for a home and a little change each week.

The scarcity of men, particularly good ones; the numerous complaints from patients and others, and the constant friction between them and the female nurses, caused the writer to study the question of their training. It would seem that their position at the present time is much the same as that of the female nurse before the advent of training schools.

I can see no reason why men should not be admitted to established training schools on the same basis as women, as many of them have the required amount of preliminary education, being found to be graduates of high schools—some have even a higher educational standard—provided they can pass the necessary requirements. If admitted, their handicap in relation to the female nurse would be about in the same proportion as the female to the male medical student. If not admitted on equal terms, then as an alternative I would suggest the method tried by me, which

was to educate them along the same lines as the female nurses, as far as possible, up to a point set by law, namely, the ability to pass the State Board of Registration examinations and thus qualify for private work on the same basis as women.

The classes were all given in hospital time—no absences were permitted on class days—the same text-books were used—all lectures by the visiting and house staffs attended, notes taken to be written out in full later, corrected as to composition, spelling, punctuation, etc.—marked on a rating of A, excellent; B, good; C, fair; and D, poor and returned—and any who felt they could not keep up with their studies were allowed to seek other work, and when a position was obtained were then allowed to withdraw honorably; all others were dismissed at once; fortunately there were a number who had requested training, who were above the average in intelligence and education, and these served as an example and a stimulus to the others. They were distinctly told in the beginning that they were being trained as nurses and not as medical students, and that at no time were they to consider themselves such. To this end, the study of anatomy, physiology, materia medica, urinalysis, etc., was based on the application of these subjects to their ward work, as the anatomical structures involved in a Colles' fracture, a fracture of both bones of the leg, or any abdominal operation; the physiological processes connected with dietaries served to the different groups of patients; a description of the drug or chemical in a medicine given, the ingredients or preparations, their dosage and action, and in urinalysis, beside the simple tests, the reasons for carefully collecting not only a first specimen but also a twenty-four hour amount, noting the general appearance, color, odor, etc., and greater attention was paid to stools, thereby causing the men to answer questions of the visiting and house staffs more intelligently—at once making them more valuable to them on their daily ward visits.

It was found by this system that they became interested in these subjects to a far greater extent than if compelled to study in the usual routine way.

Special lectures in genito-urinary and venereal diseases were given in far greater detail than the other subjects, as this class of cases would naturally come to them later to care for.

There was no difficulty in interesting the various members of the visiting and house staffs to give lectures on special subjects. Everyone invited to lecture was asked to give such lecture in the simplest manner and words—to make it as elementary as possible, which I believe is a very important point. Too often does the lecture given to student nurses go far above their heads, because the lecturer fails to remember that he is talking to nurses and not medical students, and many points are lost because they do not understand and do not feel at liberty to ask questions or are ashamed to for fear of being misunderstood.

Beginners were instructed on the wards by graduate head nurses in medical and surgical nursing, as bed making, charting and recording, measuring medicines, preparation for operation, post-operative care, preparation of dressings, etc., and this proved very valuable as an introduction to their hospital ward work.

Practical talks and demonstrations were given on the care in handling patients, ambulance, accident and operating floor work. They were instructed in the setting up of the operating room, selection of kits of instruments, of splints, dressings, etc.

Nor was dietetics neglected; a course of lectures by the dietitian, with practical work in the kitchen, was given, and this was followed later by an advanced course.

A course on ethics by the Superintendent of Nurses was also included.

The care and feeding of infants was taken up because of state board requirements, and this included simple facts concerning obstetrics and gynecology.

Too often it is said that it is not worth while to educate men as nurses, as they are deficient in preliminary education and because they will not study or apply themselves, but this I have not found to be true; on the other hand, they were eager to avail themselves of every opportunity to better themselves.

So long as we have the previously mentioned mixed class of untrained men so long shall we have poor service. How can we expect intelligent service of men who are at the beck and call of the female nurses, little better than servants, asked to do work that female nurses will not do, as the care of the toilets, polish-

ing of brasses, etc., called by their first or last names without prefix, and ordered about at will.

No longer should it be allowed to be said "that men are employed in the care of the sick chiefly as servants of women nurses."

What is the incentive for men to study and train as nurses, rather than continue as untrained orderlies?

It is: (a) the accomplishment of something, the result of which may be tangibly shown as the acquirement of a diploma or certificate—something that represents the time they have spent in hospital work.

(b) The acquisition of a state board certificate which enables them to register on the same basis as female nurses, and the results showed that with even this experimental training the number of successful ones was over 50 per cent.—the percentage of the individual ones being fully equal to that of the average female nurses.

(c) Much better wages if they remain in hospital service; still better if in private work.

Before systematic training, the only thing a man could show for the time spent in a hospital was a certificate that he "had served satisfactorily"—now he receives at the end of a definite time a diploma equal to that of the female nurses.

Every step taken in the training which helped to increase self-respect resulted in an increase in efficiency. The name "orderly" was changed to "male nurse" on the records and diploma, and the word "orderly" on the coat sleeve was done away with and a chevron was devised to show the grade of the wearer, whether a first or second year class man or graduate.

Was this experimental training worth while and did it show results? Unquestionably yes. Not only was the hospital relieved of handling a large number of more or less irresponsible men, causing many complaints and many annoyances, but it was farther reaching in that the men so trained developed as better men as well as nurses and therefore were more interested in giving better service. Complaints from patients formerly heard ceased, much better work was obtained, in times of shortage men worked unceasingly without complaint. So well did they do that they were frequently commended by the Superintendent of Nurses.

and we were fortunate in this instance of having the co-operation of one broad enough to assist in this work. To obtain the best results male nurses should work under male supervision as far as possible.

Is there a demand for trained men? Yes, for by the increase in number and in the development of hospitals there is unquestionably a need for trained men, not only for the personal care and attention of patients in the wards, but as supervisors in charge of divisions, as head nurses in charge of male wards or in charge of accident, operating and instrument rooms, etc., or in any capacity that has to do with the care of the sick or injured.

I have recently installed one of these graduates in charge of the genito-urinary department of this hospital, to the great satisfaction of the surgeons and patients, as well as of the female nurses, who are only too willing to give up this branch of nursing work.

In private nursing they have not only acted in the capacity of nurse, but as companion to their patients, assisting them in many ways in connection with their business and personal affairs.

The formation of a club or registry by groups of from six to twelve men doing private nursing has been found to be of distinct advantage to them, giving them a home with means for recreation when off cases, and late reports show that the demand for trained male nurses from these exceeds the supply.

A number of the graduates now hold responsible positions with large manufacturing and mining companies—in charge of their emergency rooms, where their services are proving invaluable to the surgeons in charge—relieving them of much detail and responsibility.

They are also entering the field of district and welfare nursing, competing on equal terms with the female nurses, and present indications point to their also being called to take up public health and other government service work.

It is pleasing to note that this systematic education has brought about a marked change in the attitude of the female nurses and their nursing associations towards the men, and I have been informed recently that they are now eligible to membership in the Massachusetts State Nurses' Association, and more recently that a number of the organizations belonging to the

American Nurses' Association had male nurses among their members and that they were represented at their last annual meeting in San Francisco, California.

In conclusion, I would add that men have the right to ask for recognition and receive training in nursing work, and that such request should be granted by the various training schools, on equal terms, or in the way heretofore mentioned if it is not practical to do the former at once, and I do not think the result will be disappointing.

The exchange of various kinds of work between the sexes makes it more opportune to train men now than formerly, and by this training we would do away with the present large untrained class which has brought male nursing into disrepute.

One graduate, who is particularly well qualified, is now doing most excellent service for his fellows by giving talks before public welfare and improvement societies to invite confidence and educate the public to offset past odium.

I believe the male nurse has come to stay and only needs the opportunity and encouragement that are justly due him to become as efficient and useful as the female. We owe him the chance—he must, and I think will, do the rest.

29th Street and Elis Avenue.

Selected Articles

CASES TREATED BY RADIUM IN THE ROYAL INFIRMARY, EDINBURGH

BY DAWSON TURNER, M.D., F.R.C.P. EDIN., M.R.C.P. LOND., F.R.S.E.

In charge of Radium Treatment at the Royal Infirmary, Edinburgh.

FORTY-ONE patients have attended for radium treatment during the past year. Twelve of these suffered from malignant disease, eleven from rodent ulcers, eleven from nevi, one from leucoplakia, one from lymphadenoma, one from spring catarrh, one from tuberculous glands, one from a tuberculous ulcer of the dorsum of the hand, one from a papilloma, and one from hypertrichosis.

Many of these patients received prolonged treatment or attended a considerable number of times; thus, in some of the malignant cases, whenever indeed it was possible, a tube of radium was inserted into the growth and maintained there for periods up to twelve days, while at the same time external treatment was employed so as to subject the growth to a cross fire of rays.

The treatment of port wine stains must also be very prolonged; as a cosmetic effect is desired, very small doses have to be given, and the result carefully observed, lest an atrophic condition of the skin be produced.

Radium treatment, as a rule, is conducted in the following manner: A dose large enough in the experience of the expert to produce the desired effect is administered, and the patient is sent away and told to report himself in two or three weeks, for the full effect of any dose is not manifested for three or more weeks. Another dose, if necessary, is then given, and the patient again sent away for a fortnight. I have not time here to refer to the question of dosage or of screens.

NEVUS.

The cases which have been most benefited during the year have been those of nevus and rodent ulcer. Of eleven nevi—

of which two were port wine stains—seven were cured, three are under treatment, and one (port wine stain) did not return.

RODENT ULCER.

Rodent ulcers, if not affecting mucous membranes, cartilage, or bone, are also extraordinarily amenable to radium. The reasons why radium is so superior to carbonic snow or zinc ionization or excision are, first, because the rays penetrate deeply—in fact, right through the body (the gamma rays will penetrate 10 in. of lead), so that the very roots of the rodent are attacked; secondly, because the treatment is absolutely painless; and thirdly, because the cosmetic result leaves nothing to be desired. Of eleven rodent ulcers six were cured, one is under treatment, three did not return, and one was unsuitable for radium treatment. Of the cases that were cured, one affected the upper lip, and was on the point of penetrating it. Three were in the furrow between the nose and cheek; they had received unavailingly prolonged treatment with x-rays. One, a case of Professor Caird's, was on the ala nasi; it measured $\frac{3}{4}$ in. by $\frac{1}{2}$ in., and was on the point of penetrating; one dose of 65 milligram-hours sufficed to cause complete healing with a beautiful cosmetic result and no contraction. The disease has, however, recurred in this case a little distance off on the tip of the nose. An application of radium has accordingly been made to it, and I have no doubt of a successful issue. The sixth was above the right eye. In another case of Mr. Caird's—a male aged 61—the disease began many years ago as a pimple on the right side of the nose; eight years ago this was removed; on its return it affected the internal canthus, and Mr. Caird operated twice, in 1909 and 1912; on the latter occasion, recognizing that he had not removed all the growth, he recommended him to me for radium treatment. I placed two tubes of radium into the cavity, which was nearly 2 in. deep, and kept them there for thirty hours; no screen but a thin tube of aluminium was employed. This was on May 4th, 1912. In July the cavity had almost filled up, but for precaution's sake I gave a dose of 47 mg. of radium for thirty minutes. In December, 1912, he called, quite cured.

Two of the cases of rodent ulcer were treated by the insufflation of the radio-thorium emanation. One of these was a male,

aged 49, recommended by Professor Caird; six years previously enucleation of the left eye had been performed by Dr. G. Mac-kay. The disease had recurred, and now formed a sloughy ulcer, about the size of half a crown, below the left orbital cavity, leading to extensive excavations beneath the cheek. As the disease was too extensive and too difficult of access for the limited amount of radium at my disposal, the idea occurred to me to treat it by blowing into it the radio-thorium emanation, which would be carried into the remotest corners of the excavations, and would coat the walls with a highly radio-active deposit. I did this some twenty times in the course of a few hours, and the immediate effect seemed to be to diminish the fetor; unfortunately the patient did not return for further treatment. The second case treated by the radio-thorium emanation was a male, aged 60, recommended by Mr. Wallace. The duration of the disease was fifteen years; he had been treated by x-rays, and Mr. Wallace had performed enucleation of the left eye three years ago. A later operation had also been performed by Mr. Wallace. At the time the radium treatment was begun there was an ulcer with everted edges occupying the left superior border of the nose, and extending deeply into the orbital cavity. As he was an in-patient I instructed the nurse to insufflate the cavity with the emanation every half-hour during the day for one minute at a time. This was done for ten days, when it was thought advisable to supplement the emanation by the application of solid radium. After four days of the combined treatment he was sent home. He had had 176 insufflations of the emanation and 235 milligram-hours application of solid radium. A fortnight later he returned very much improved; the nasal ulcer was practically healed. When another fortnight had elapsed he was readmitted and treated again by the combined method for three days. On his reporting himself a month later (January 8th, 1913) there was further improvement. The total dose was 208 insufflations of the radio-thorium emanation and 675 milligram-hours of solid radium. He has not reported himself since.

MALIGNANT DISEASE.

Twelve cases of malignant disease attended the department during the year. With one exception they were all inoperable

cases; with two exceptions they were either recurrences or secondary deposits. Of these twelve cases one was healed with a sound scar, as well as a recurrence in the neighbourhood; three were improved; one exhibited temporary improvement; one, a carcinoma of the pharynx, was unrelieved and died; of the remaining six, two are still under treatment, one did not return for treatment, one refused treatment, in one a prophylactic dose of radium was given after an operation for removal of a sarcomatous growth in the groin, and in one the growth was so extensive as to render a resort to treatment with a limited amount of radium hopeless.

With the exception of the sarcoma referred to above all the cases were of a carcinomatous nature; and in five of them the upper or lower jaw was the seat of the disease. Brief details of the cases are as follows:

1. A female, aged 49, with a recurrent epithelioma of the right ala nasi, recommended by Mr. Wallace. The patient had long suffered from an ulcer on the ala nasi; prolonged treatment with x-rays and weak radium preparations, followed by excision. Condition on admission on June 25th, 1912: There is an ulcerating crack on the external surface of the right ala nasi. A single dose of 95 mg.-hours of radium bromide screened by glass and aluminium was administered. On July 9th there was a good reaction; the scab did not come away until the middle of September, when the ulcer was found to be completely healed over. On January 28th, 1913, the scar was still in a perfectly sound condition, but a small ulcer had appeared just within the nostril on the septum nasi. This was given a dose of 40 mg.-hours of radium bromide, screened as before by glass and thin aluminium, with a completely successful result.

2. A female, aged 70, recommended by Dr. Sym. Epithelioma of one year's duration affecting the upper lid and canthi of the left eye. Had twenty-four full doses of x-rays. Condition on admission: There is an irregular ulcer eating away the lower margin of the upper lid and involving the canthi; the body of the lid is hard and swollen. Treatment commenced on January 20th, 1912, and continued at intervals to May, 1912. Great improvement followed. The ulcer healed and the swelling disappeared. On May 22nd, 1912, Dr. Sym examined her, and

wrote: "There is very great improvement, very great indeed, but whether the cancer is all gone or not I can't be sure." On June 20th the patient returned with a hard lump external to the external canthus; this was given one good dose of radium and the patient sent home. On October 29th, 1912, she returned much worse, with the bone affected. Mr. Hodsdon excised the growth by an operation which opened into the frontal sinus. A prophylactic dose of 210 mg.-hours of radium was then administered.

3. A male, aged 44, recommended by Professor Caird. A rapidly-growing recurrent epithelioma of the right upper jaw, operated on twice within five months by Professor Caird. There is a large ulcer extending backwards on the mucous membrane of the buccal cavity on the right side; the skin outside is red and angry looking. On November 7th, 1911, external and internal applications of radium were commenced; the external applications were shielded by a sheet of silver half a millimetre in thickness, the internal by a thin sheet of aluminium. On December 4th, 1911, he was sent home after a total dose of 1,011 mg.-hours. The disease had ceased to extend and considerable improvement was manifest. On January 9th, 1912, he returned in a worse condition; there was a large external swelling, and Professor Caird thought that further treatment would be useless.

4. A female, aged 42, recommended by Mr. Hodsdon. An epithelioma following lupus; duration thirty years. The disease has been treated by both medical and surgical means; it has had courses of x-rays extending over years; it has been scraped, cauterized, and partially excised. Present condition: Below the left nostril there is an irregular ulcer eating into the lip; it is 2 in. broad by 1 in. long, and it has raised margins, except where it is spreading on to the mucous membrane of the lip; there is a perforation below the left nostril. Treatment was begun on November 28th, 1912; 25 mg. of radium bromide (International standard), screened only by glass and aluminium, were applied to successive areas of the ulcer for a few hours daily during a week; the dose amounted to 1,620 mg.-hours. This was followed in three weeks' time by a strong reaction, and afterwards considerable improvement was manifest, healing was going on above, granulation tissue was present, and malignant characters were absent. The patient is to return for more treatment.

5.-A male, aged 72, recommended by Dr. Elder. Malignant disease of the fauces and pharynx. Duration more than a year; difficulty in swallowing and speaking. An irregular swelling can be observed, involving the soft palate and uvula and causing great deformity. Left cervical glands enlarged. Both Professors Alexis Thomson and Caird considered the case quite inoperable. With the hope of relieving his symptoms, radium treatment was commenced. On September 19th, 1912, a capsule, containing 40 mg. of radium bromide, was attached to an aluminium rod and held by the patient against the affected part for one hour two or three times a week; only an aluminium screen was used. By November 28th, 1912, the patient had received a dose of 388 mg. hours. The applications appeared to relieve his pressing symptoms, but he gradually sank and died on December 14th, 1912.

6. A male, aged 35, recommended by Professor Alexis Thomson. Diagnosis: Round-celled sarcoma situated in the groin. Duration twelve months; was admitted to the Royal Infirmary on January 11th, 1913, complaining of a lump the size of one and a half fists in the groin and of increasing weakness; the left leg was edematous. On January 17th, 1913, Professor Thomson removed the growth, which proved to be a round-celled sarcoma. On January 30th, 1913, a tube of glass in an aluminium cover, containing 10 mg. (International standard) of radium bromide, was inserted into the wound and kept there for twenty-four hours. This was intended to act as a prophylactic measure.

7. A female, aged 54, recommended by Mr. Miles. History: In September, 1911, the patient had been admitted to Chalmers Hospital, complaining of a hard, painful lump in the left axilla. Mr. Stiles removed the mass and the breast; both were found to be the seat of a medullary carcinoma. Readmitted May 28th, 1912, with a rapidly growing recurrence in the scar; this was excised on May 31st, 1912. Returned at the beginning of 1913 with a secondary growth affecting the sternum. The patient recommended to the Royal Infirmary; was admitted by Mr. Miles. Projecting from the sternum was a hemispherical growth, in area about the size of a teacup saucer and raised nearly an inch above the general surface. The skin over it was reddened. The patient complained of spasms of severe lancinating pain. Treatment:

Two tubes of radium, each containing 5 mg. (International standard), were introduced by Mr. Miles into the growth, screened only by glass and aluminium, and were kept in for seven and for twelve days respectively, being moved occasionally so as to expose a fresh area to the radiation. At the same time applications of 25 mg. (International standard) screened by silver were made externally. The total internal dose was 2,400 mg.-hours; the total external dose was 800 mg.-hours. Under this treatment the tumor rapidly flattened down, and in six weeks' time had disappeared. Some pus was discharged from the incisions, and a good deal of reaction was manifest on the skin. The lancinating pain disappeared shortly after the applications. The patient expressed herself as very grateful. She is still under observation.

Of the remaining 5 cases 1 did not return for treatment, 2 are still under treatment, 1 refused treatment, and in 1 treatment was refused on account of the extensive nature of the growth.

LEUCOPLAKIA.

A male, aged 52, recommended by Professor Alexis Thomson, has attended since October, 1911, for radium treatment. He has a specific history. The duration of the disease was one year. On the surface and side of the left half of the tongue there were several whitish, hard patches somewhat raised above the surface. Ten mg. of radium bromide (International standard) were enclosed in an aluminium box and applied for an hour at a time twice a week to the patches. The effect of the treatment is to improve and check the development of the disease, because if it be intermitted, as in the holidays, the condition rapidly becomes worse. The patient refuses operation and he has had prolonged courses of internal treatment, also an injection of salvarsan. Stronger and more prolonged doses of radium would, I think, produce more decided benefit.

LYMPHADENOMA.

A male, aged 18, was recommended by Dr. Byrom Bramwell for radium treatment in November, 1911. There were growths round the neck and in the groin and axilla. The circumference of the neck measured $17\frac{1}{2}$ in. The neck was treated by external applications screened by silver. No improvement resulted, and

after a total dose of 1,933 mg.-hours given in one week treatment was suspended.

SPRING CATARRH.

A male, aged 9, recommended by Dr. George Mackay, was an old case, whose right eye had already been cured by radium treatment, but whose left eye had not had sufficient treatment. He was given a dose of 5 mg.-hours by the application of a 10-mg. capsule to the eyelid for half an hour. This patient had first attended in March, 1910. Both upper lids were covered on their internal surface with the typical granulations and pavement-like blocks. The lids were much swollen. The right lid only was first treated, and in three months was practically well after a dose of 32.5 mg.-hours. Treatment of the left eye was then begun.

TUBERCLE.

Tuberculous Glands.—Only one patient, recommended by Dr. J. Burnet, suffering from enlarged cervical glands, attended the department, and he did not return.

Tuberculous Ulcer.—A boy, aged $3\frac{1}{2}$ years, recommended by Dr. Railston Richardson, attended for radium treatment of tuberculous ulcer on the dorsum of the right hand. It had existed for two years and had been treated with iodine, caustics, etc. There were two patches close together, measuring nearly half an inch in diameter, dark red, and slightly elevated. Treatment was begun on December 3rd, 1912, and continued for a fortnight, by which time the dose amounted to 20 mg.-hours. Only a screen of aluminium was employed. In a month the patches were covered by a good scab, which fell off at the end of January. The patches had almost disappeared, but to aid in the cure a further dose of 13 mg.-hours has been administered. The patient is still under observation.

PAPILLOMA.

A female, aged 51, recommended by Dr. Davidson of Kelso, was admitted on October 8th, 1912, with a papilloma on the left side of the nose. It was half an inch wide and raised a quarter of an inch above the surface, and it was composed principally of horny material. The duration had been about five years, but

latterly it had been growing more rapidly. The patient had had a previous growth removed some years ago from a position a little higher up. A dose of 35 mg.-hours, screened by aluminium, was administered by a single application. In a fortnight the growth fell off; in seven weeks there was perfect healing, the site of the growth being covered by a beautiful supple skin.

HYPERTRICHOSIS.

A female, aged 25, recommended by Dr. Fleming, attended for a week during September, 1912, for the radium treatment of this condition. The patient had a thick, hairy growth round the lower border of the chin. After the patient had been made aware of the difficulties of the method of treatment, applications screened by aluminium of 5 mg.-hours were made over successive areas. These proved to be insufficient to produce epilation. The patient proposes to return later on.—*British Medical Journal*.

NEW LADY SUPERINTENDENT AT GUELPH GENERAL HOSPITAL

MISS ANNIE FORGIE has been offered and has accepted the position of Lady Superintendent of the Guelph General Hospital. Miss Forgie comes originally from Claremont, in Ontario County. She is a graduate of the Rochester General Hospital, and has had a wide experience in other large hospitals. Her last appointment was as Superintendent and Business Manager of the Galt Hospital, at Lethbridge. Miss Reekie, the retiring Superintendent at Guelph, leaves for Regina, where she will become Superintendent of the General Hospital in that city.

Society Proceedings

THE ONTARIO MEDICAL HEALTH OFFICERS' ASSOCIATION MEETING

MEDICAL Health Officers to the number of nearly two hundred and fifty from various parts of the Province attended the Fifth Annual Conference of the Ontario Health Officers' Association, which convened on May 29th in Convocation Hall. Dr. A. J. Macauley of Peterborough, the acting President, presided in the absence of Capt. A. W. McPherson of Peterborough, the President, who is in Flanders. By a unanimous vote Dr. McPherson was re-elected President. A number of members were in khaki.

"Modern Methods of Diagnosis and Treatment of Diphtheria" was the title of an extremely educational paper delivered by Dr. W. H. Park, Director of Laboratory, Public Health Department, New York City. Dr. Park stated that his Department was specializing in the matter of reducing the amount of diphtheria among children. In this connection Dr. Park pointed out that in order to carry out the practical work the Department had divided certain sections of the city into Medical Districts and grouped the children for the purpose of making tests and, at the same time, obtaining more thorough information as to the causes for the spreading of the disease.

Dr. Park said that the scheme had been productive of wonderful results, and he urged the establishment of similar work in all large cities. In dealing with the question of antitoxine, Dr. Park said:

"It seems strange that, after twenty-one years of experimenting, the Medical Fraternity are still undecided as to the amount to give and the way to give it. From practical experience I feel satisfied that the full amount of antitoxine required should be given in the first injection. I think a lot of harm is done if the full amount is not given in the first injection."

With the assistance of several charts Dr. Park described its uses in various stages and the results obtained, both in the cases of children and adults at ages ranging from two to twenty-one

years, and upon animals. He stated that fully seventy per cent. of horses were diphtheria carriers.

At the Morning Session there was a spirited debate following a paper, "Should the Bread-Winner Be Quarantined?" which was given by Dr. V. A. Hart of Vespra. It was pointed out that under the law the whole matter of quarantining an individual rests with the discretion of the Medical Health Officer, except in the case of smallpox. The general opinion was that the Officers do not make exemptions in cases where the bread-winner does not exercise particular care in his home.

In a discourse on "Suggestions for Improvement of Association Meetings," Dr. F. A. Dales of Stouffville suggested that the Association should carefully consider whether or not the public should pay the wages of the bread-winner while under quarantine. In this connection he pointed out that the isolation of the individual prevented the spreading of the disease. Consequently the public is safeguarded and, therefore, should make some remuneration to the man who has to remain idle.

Dr. Dales also expressed the opinion that the Association should be divided into two sections, one for cities and towns, and the other for smaller towns and villages and rural municipalities. He believed that if this was done and the Provincial Health Department placed one or two expert officials at the head of each county it would do much to minimize the spread of disease, and that in a few years hence a cleaner and more healthy nation would arise.

Dr. G. R. Cruickshank of Windsor, who has been specializing in the matter of reducing the large volume of tonsilitis and adenoids diseases which prevail throughout the Province, especially among school children, stated that he had obtained some very good results from tests made in the schools. He believed that if the tonsils were in a healthy condition in a child at the age of ten they should be removed. He had no doubt but that they were responsible for a great many diseases which develop. He had traced diseases which undoubtedly had their origin from that source.

As a means of reducing the amount of tonsilitis Dr. Cruickshank offered the following suggestions: The abolishing of the use of baby's comforts, which convey a lot of unnecessary dirt

into the mouth; the proper ventilation of sleeping apartments and schoolrooms and the proper care of the teeth.

The following papers, all of which were of a most instructive character, were given: "The Quarantine Period for Measles," Dr. M. B. Whyte, Isolation Hospital, Toronto; "Measles," Dr. A. D. Smith, Mitchell; "Some Observations of Typhoid Fever in Toronto," Dr. Fred Adams, Epidemiologist, Department of Health, Toronto; "Epidemic Cerebro-Spinal Meningitis," Dr. J. G. Fitzgerald, University of Toronto; "Deductions of a New Ontario Medical Officer of Health," Dr. Edgar Brandon, North Bay.

In the evening two interesting papers dealing with the hospital accommodation and the system of sanitary arrangements at the Front, illustrated with limelight views, were given by Major W. D. Sharpe, R.A.M.C., Brampton, and Capt. Ruggles George, Toronto, both of whom recently returned from the scene of hostilities.

In dealing with "Sanitation in Serbia," Major Sharpe said the Americans claimed to have improved conditions in this respect in Serbia. While this was true to a certain extent, the British had had more to do with the introduction of modern sanitary conveniences in the Far East than any other nation.

"The Serbs have many peculiar ideas of sanitary conveniences," asserted the Major. "They have been downtrodden by Eastern civilization, but in recent years the better classes in Serbia, especially in Belgrade, have risen in their might and adopted the most modern sanitary and ventilating conveniences."

Capt. Ruggles George showed a number of attractive war scenes, embracing the Canadians mobilizing at Valcartier and in training at Salisbury Plains. He also showed some interesting pictures of the hospital arrangements at the Front.

War Hospitals

DR. WILFRED T. GRENFELL'S EXPERIENCES IN THE TRENCHES

DR. WILFRED T. GRENFELL honored Toronto with a visit on May 19th last and addressed a very large audience in the Convocation Hall of the University of Toronto on the evening of that day. Dr. Grenfell was ever a man of war, and the conflict in France and Flanders, from which he has just returned, he has found to be only relatively different from that which he is about to resume in Labrador. The Doctor spoke in behalf of the Red Cross Society, and told of what he saw of the everyday life on the battlefield, and during his hour's talk one could have heard a pin drop on the floor, so great was the silence.

"War and peace are not so dissimilar as one might suppose," said the Doctor in opening his story. "Doing one's bit at the front is very much the same as doing one's bit at home in ordinary life. It takes just as much courage to face everyday problems cheerfully as it does to face a foe in war. I have seen men under pitiable conditions in the trenches who were more cheerful than men in luxurious homes. I have looked in the faces of a good many dying men in these last months, to whom I could offer no other help than to take their hand and say, 'Thank God you did your bit when you had your chance.'"

Speaking of the attitude of the troops to religion, Dr. Grenfell said he could not be sure that they were all nominal Christians, but there was an atmosphere of unselfishness pervading the life at the front. "Men were so unselfish that they regarded it as a privilege to be permitted to crawl over a parapet to fetch in a wounded comrade. It is an atmosphere in which Christ himself might walk. Though we are losing men at the war, for every man that falls two new men are made. However many men Canada may lose, ten thousand times as many would have been lost if Canadians at such a time as this should have stood aside and said, 'We are neutral on this question.' I feel a great reverence in the face of a Canadian audience when I think of what I saw at Ypres."

"I have met people in the United States who are so undecided upon the war that one would almost think that Belgium made war upon Germany to extend her territory! Belgium went to war as Christ went to Calvary: because she believed it was right to do so. I do not know how any man, when it comes to piracy and sins of that kind, can at the end of his life stand before the Almighty and say: 'I have fought a good fight and I have kept the faith, and henceforth there is laid up for me a crown of righteousness.'"

"I am not going to tell you a lot of horrible stories about German atrocities, but I can tell you one which I believe to be true." The Doctor then told of the shooting of a Belgian boy of twelve years who had shouted "Vive la France!" as the German soldiers passed by, mistaking them for French soldiers.

LETTER FROM DR. HARLEY SMITH

May 13, 1916.

DEAR DR. YOUNG,—Thank you cordially for your kind and interesting letter of 14th ult. Our hearts are still in the dear home town. There is not a man of our unit who has not been longing to see his precious loved ones. We trust the time will not be long before we shall be again united with the valued friends of many years.

We have at Orpington an institution that reflects great credit upon the Province of Ontario. One could not find a better equipped hospital anywhere. The wards are arranged on the slope of one of the low Kent hills in such a way as to allow them to be flooded with sun and light. The green and dark brown coloring of the walls produces a soothing effect to the eye. The two thousand windows enable the patients to be constantly in the open. The operating theatre would cheer the heart of even the most fastidious Toronto surgeon. Equipped with sterilizing, anesthetic and instrument rooms; capacious enough for four tables; furnished with perfect natural and artificial lighting, it leaves nothing to be desired. The kitchen is commodious enough for a brigade. The bread is baked in tiers of forty-four ovens, heated by steam. We find here a butcher's shop, grocery and

provision stores and the electric light plant. In our mess reading room there is the nucleus of a very good medical library. The members of the staff, having the best of provision made for their comfort, are anxious to do a high grade of work for the brave British soldiers—without distinction of color, creed or birthplace—who are entrusted to their care; and thus, not only to have the consciousness of duty well done, but also to reflect glory on the generous Government of Ontario, that has so fittingly made this magnanimous gift to the Empire's needs. Our chiefs of staff, Col. Chambers and Col. Cameron, enjoy our respect and love, and will be loyally supported by their junior officers. At present, owing to the preponderance of medical cases, we internists are able to lord it over the surgeons. Our Commanding Officer, Col. D. W. McPherson, is the right man in the right place. He has a big job on his hands, in organizing a hospital of 1,040 beds. But his unfailing good nature and courtesy towards officers and men, and his long experience in France and England (as well as in Canada), are standing him in good stead, and the work of organization is progressing rapidly and surely.

Our mess is fortunate in having the gracious Col. Graham Chambers as President. It has decided to be a "dry" mess, influenced doubtless by the fact that our hospital represents a Government and people that have taken up a strong position on the question of the use of alcoholic liquors.

We have already had the good fortune to see some of our old Canadian friends—Col. Ross, Col. Rudolf, Col. Adami, Col. Wallace Scott, McGregor Young and Mr. Robert Moud (brother of Sir Alfred Moud), a bacteriologist who does not believe in the sterilization or pasteurization of milk. A few days ago, while visiting the old Woolwich Hospital, built about the time of the Crimean War, I met Dr. Carruthers, who was at Moorfields with Colin Campbell. The men on our staff are a fine lot, but decidedly unmusical. However, after a hard struggle, we have induced some of them to cultivate their voices—towards midnight. Your heart would rejoice to hear Mac Crawford, Victor Graham, Duncan Campbell, Major MacKay (our dwarf pianist) and John Kane united in a series of college songs. Judging by their rapid progress, Caruso will soon have to look to his laurels. Major Norman Wilson, looking hale and hearty again, has just

joined our staff. There was general and heartfelt grief over the sad news of the deaths of Dr. Yellowlees, Dr. Burritt and Dr. B. E. Mackenzie.

With kindest regards to Mrs. Young and yourself,

Faithfully yours,

HARLEY SMITH.

Book Reviews

Studies in Ethics for Nurses. By CHARLOTTE A. AIKENS, formerly Superintendent of Columbia Hospital, Pittsburg, and Director of Sibley Memorial Hospital, Washington, D.C. - W. B. Saunders Company, Philadelphia and London. 1916.

Miss Aikens has again written a wonderful and unique book. This is one in which everybody can read with interest things concerning himself, his parents, or his sister. It is a book which should be purchased in large numbers by the superintendent of every training school to send to young women contemplating the study of nursing, because this is their Book of Life. In this they will find all their difficulties truthfully stated, and a way to conquer enunciated. Hitherto books on ethics have been rather dry sermons of an abstract nature, but Miss Aikens' pages are filled with concrete words that pulsate with live, practical wisdom. Miss Aikens has recognized, evidently from close daily contact with her pupils, that the hard part in nursing is not in having a great number of heavy, laborious treatments to give, but in missing some much-needed cuff buttons when all ready to go to class, or a raincoat, or some money left in a drawer that must be unlocked—not in pursuing new, strange technical studies, but in having to do much more than one's just share because some other nurse may be philandering—or, again, not in running up and down flights of stairs in an unfamiliar house when on private duty, but in discreetly handling all the vagaries of an anxious, distressed family. The examples given are like a chart of an unknown sea to the novice nurse. Each reef is distinctly marked with a bell or a buoy, so that she may steer her course clear of it into a safe haven.

The book is clearly typed, of good appearance and volume, 320 pages, with an excellent index. It should make a strong bid for instantaneous adoption.

A Reference Hand-Book of Obstetric Nursing. By W. REYNOLDS WILSON, M.D., Former Visiting Physician to the Philadelphia Lying-in Charity. Illustrated. Third edition, thoroughly revised. Philadelphia and London: W. B. Saunders Company. 1916. Toronto: J. F. Hartz Co., Limited.

The third edition of Dr. W. Reynolds Wilson's Hand-Book has been considerably improved. It contains some new material on scopolamin—morphine anesthetic and the uses of nitrous-oxid-oxygen gas. It also devotes some space to the caloric estimation of food values for the infant. The text as a whole has been largely rewritten. We heartily commend the book to nurses about to take their instruction in obstetrics.

First Year Nursing. A Text-Book for Pupils during their First Year of Hospital Work. By MINNIE GOODNOW, R.N., formerly Superintendent of the Woman's Hospital, Denver, and Directress of Nurses at Milwaukee County Hospital, etc. W. B. Saunders Company, Philadelphia and London.

From Miss Goodnow's facile pen comes a new edition of her valuable book for pupils. Miss Goodnow has the happy knack of hitting the bull's-eye every time by mentioning with emphasis just the points on which a novice might seriously err. This book has just been entirely gone over, added to, and modernized, with extra illustrations, all of which are very clear. There are many given which are not to be found in the standardized text-books for nurses. The only point to be made in criticism is that a nurse who is in her first year is not usually permitted to do such advanced work as is referred to in the later chapters. Nevertheless she may take this information on with her into her second year. The binding, type and paper of this edition are of the best quality.

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The Art of Anesthesia. By PALUEL J. FLAGG, M.D., Lecturer in Anesthesia, Fordham University Medical School; Anesthetist to Roosevelt Hospital; Instructor in Anesthesia to Bellevue and Allied Hospitals, Fordham Division; Consulting Anesthetist to St. Joseph's Hospital, Yonkers, N.Y.; Formerly Anesthetist to the Woman's Hospital, New York City. 136 illustrations. Price \$3.50. Philadelphia and London: J. B. Lippincott Company.

It has been a matter of surprise and some comment that more literature has not of recent years been devoted to the subject of anesthetics. It must be admitted that medical practitioners in general practice have far too limited a knowledge of the proper administration of an anesthetic. This should not be, especially in rural practice, where men are so often called upon to anesthetise a patient without any assistance other than that of a friendly neighbor. The administration of an anesthetic is far more than a mere mechanical performance. It is, as the author states, an art, and after looking through Dr. P. J. Flagg's book we are satisfied that, if read as it deserves to be read, fewer mistakes will be made and fewer lives sacrificed. Buy it. It is well worth the price.

Text-Book of Anatomy and Physiology. For Training Schools and other Educational Institutions. By ELIZABETH R. BUNDY, M.D., Member of the Medical Staff of the Woman's Hospital of Philadelphia; Gynecologist, New Jersey Training School, Vineland; formerly Adjunct Professor of Anatomy, and Demonstrator of Anatomy in the Woman's Medical College of Pennsylvania; formerly Superintendent of the Connecticut Training School for Nurses, New Haven; etc. Fourth edition, revised and enlarged, with a glossary and 243 illustrations, 46 of which are printed in colors. Philadelphia: P. Blakistons Son & Co., 1012 Walnut Street.

We have felt for a long time that the teaching of nurses is often badly adapted to their requirements and more suited to the medical student than the nurse. This work, written by a medical graduate who has had a large experience in the training of nurses, is as simple and practical as one could wish. The numerous illustrations, taken from the best authors, will prove very helpful. In every way we think the work well suited for the class for whom it is intended.

W. J. W.

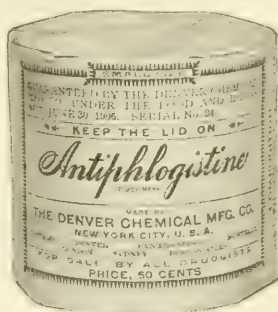
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A NEW HOSPITAL FOR SHOCK CASES

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The present institution at Cobourg will be immediately converted into a Military Hospital by the transfer of some 180 female patients to the new Hospital for Mental Diseases at Whitby. It is expected by the first week of July the Cobourg Hospital will be ready to receive over 50 patients, which cases will be increased from time to time as necessity arises. The Medical Staff and Nurses, with the necessary facilities and organization for this Hospital, will be provided by the Provincial Secretary's Department, and preparation is being made to increase the accommodation by the erection of additional buildings, should it be found that this is needed.

The Ontario Government are to be congratulated upon their most recent step in aid of returned soldiers. The Government is following the best practice as it exists to-day in England, where they have already one or two such institutions.

It is hoped that in about two months' time one section of the Hospital will be entirely completed, which will permit the handling of any number of cases as is contemplated under the new arrangement, up to perhaps 500.

The need for special facilities for the treatment of mental and shock cases arising out of the War is imposing an unforeseen burden on the Medical branch of the military organization of Canada. The Dominion Government will pay to the province a maintenance charge of so much per day per patient, and the entire resources of the department will be made available for the purpose of securing for those who are sent to Cobourg Hospital the best treatment known to science. The equipment will include hydrotherapeutic and electrotherapeutic baths, with special wards to deal with the different classes of patients.

GRADUATING EXERCISES AT THE HOSPITAL FOR MENTAL DISEASES

THE Graduating Exercises of the Toronto Hospital for Mental Diseases, held at 999 Queen Street West, on June 15th, gave evidence of an excellent year's work, and of war work, too, done through the hospital's offshoot in the Psychopathic Department of the Ontario Government's Military Hospital at Orpington. The proceedings were presided over by Mr. S. A. Armstrong, Assistant Provincial Secretary. Dr. Helen MacMurchy addressed the graduates and the diplomas were presented by Mrs. J. M. Forster and Mrs. Forbes Godfrey. The Hospital for Mental Diseases is affiliated with the Western Hospital, Toronto, in a post-graduate course. The prize for highest marks was carried off by Miss Wylie.

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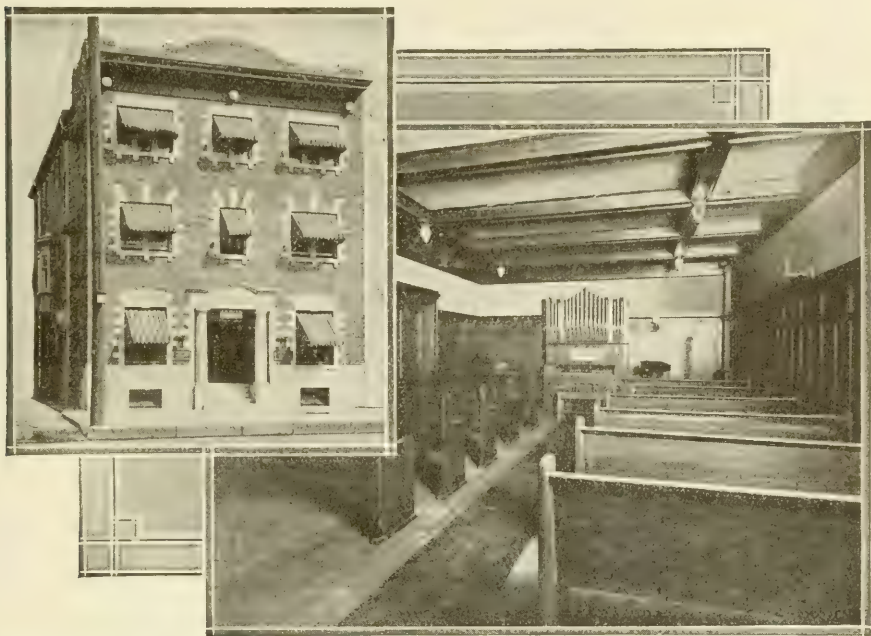
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The Keith Ventilating Fan

SHELDONS Limited, makers of the Keith fan for ventilating and other purposes, are very busy. They have been running night and day for the past fifteen months. This firm has recently secured the contract for ventilating equipment for St. Joseph's Hospital, Hamilton, which consists of three special Keith fans with direct connected motors. While the Canadian trade in ventilating equipment has been rather quiet since the war began, owing to there being so few large buildings erected, still this firm is getting their share of the business, and in the past few months have received orders for quite a number of fans for export.

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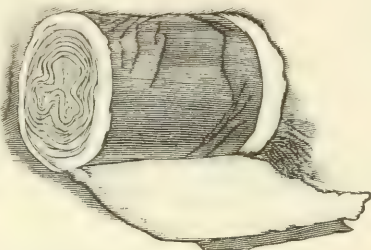
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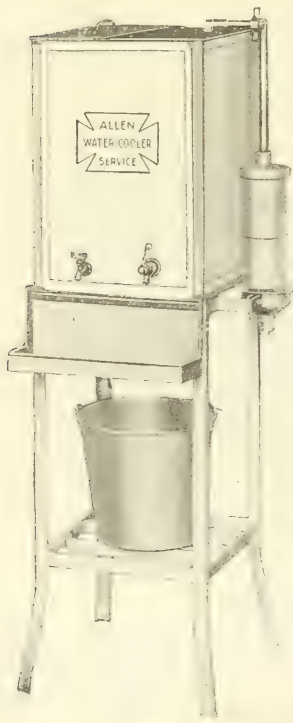


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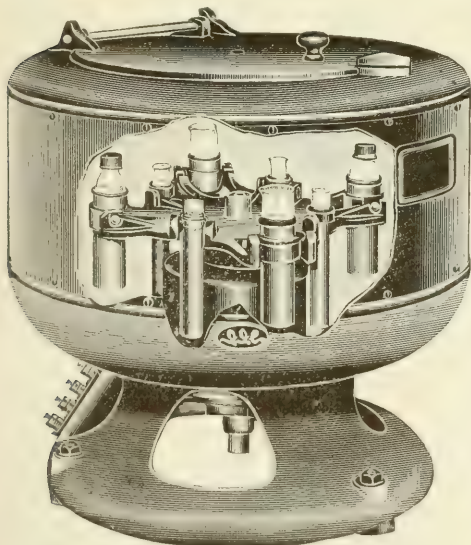
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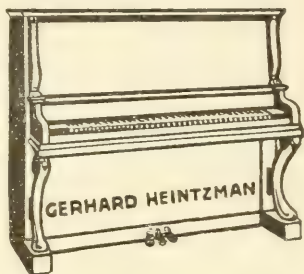
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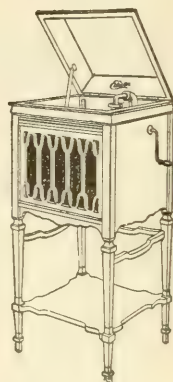
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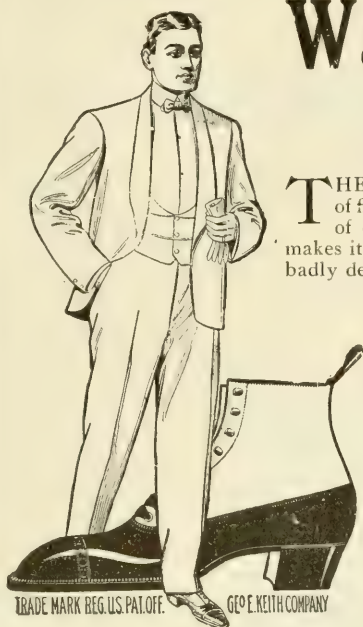
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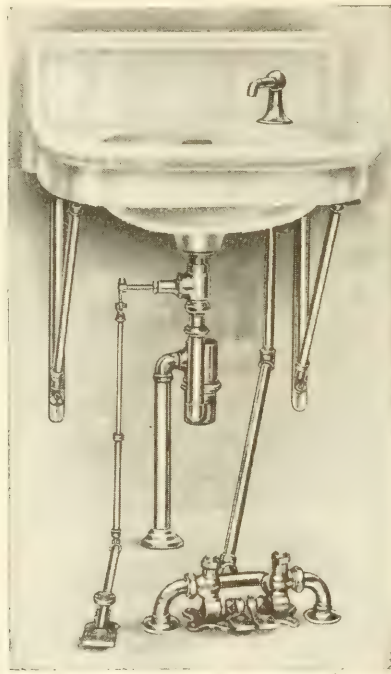
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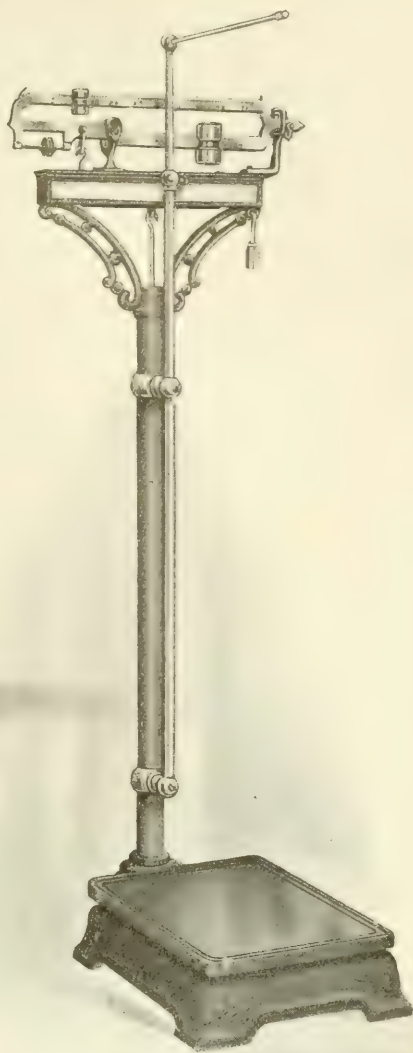
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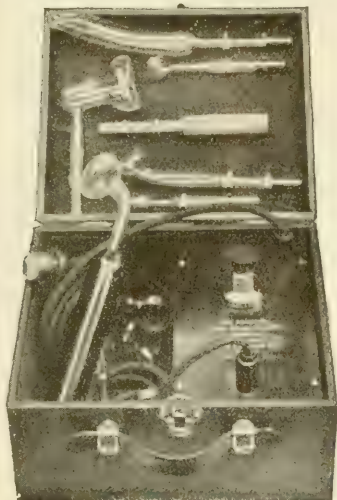
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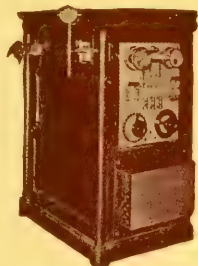
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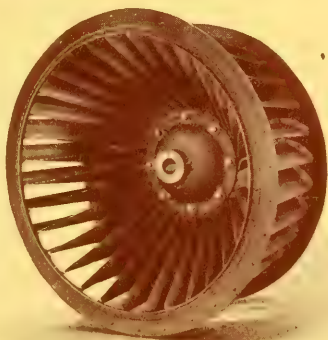
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No. 2

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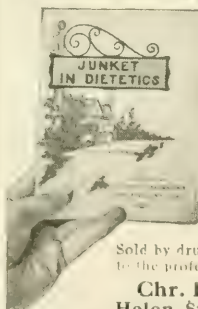
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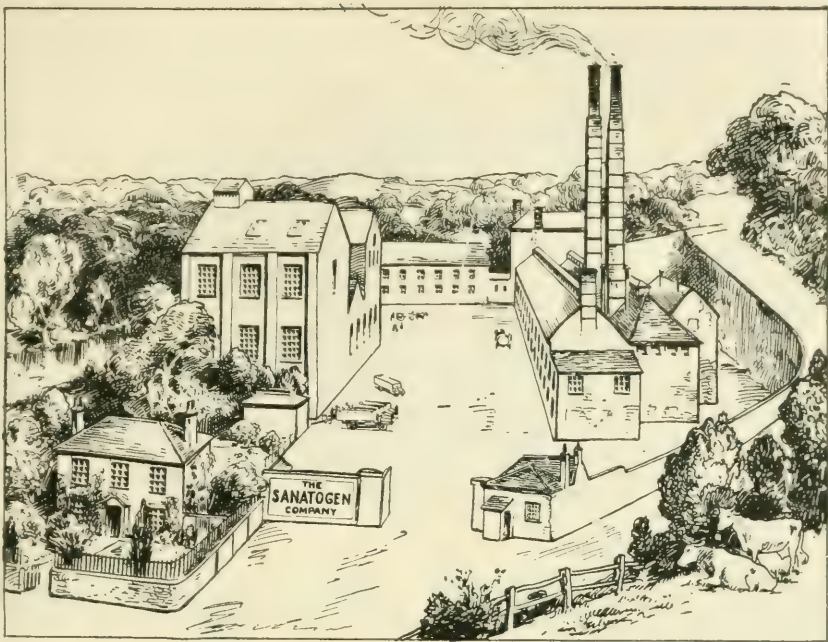
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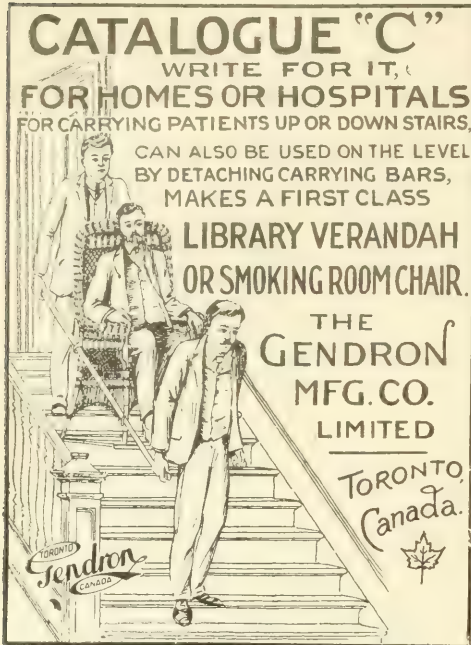
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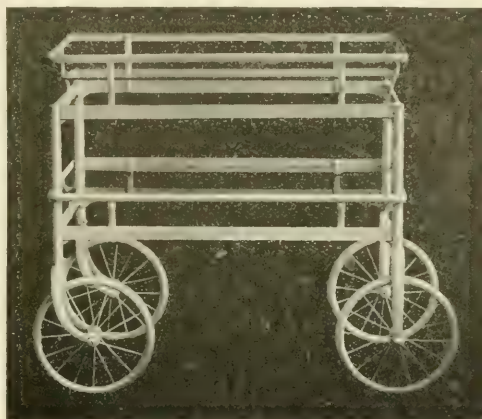
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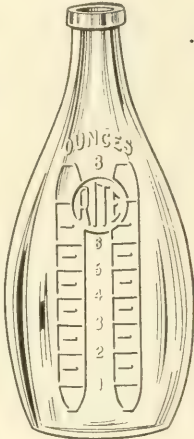
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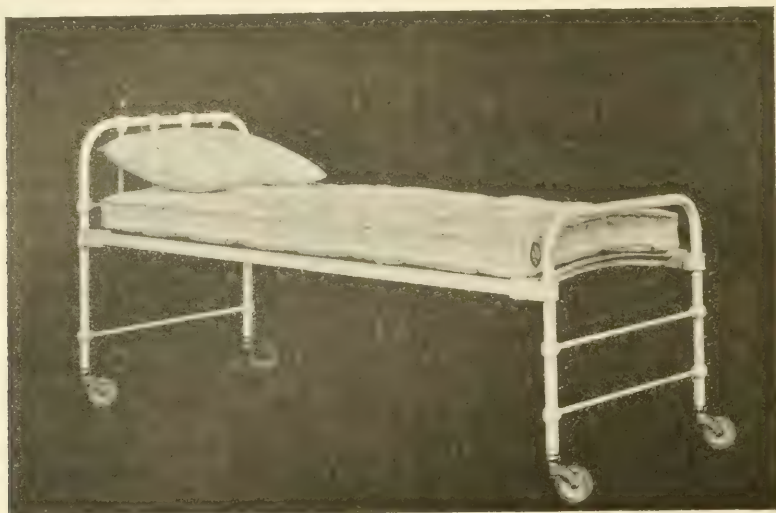
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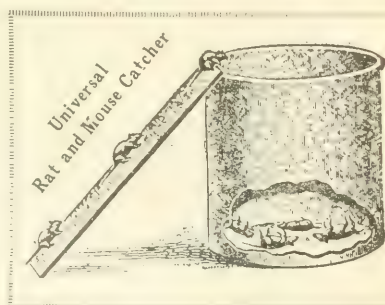
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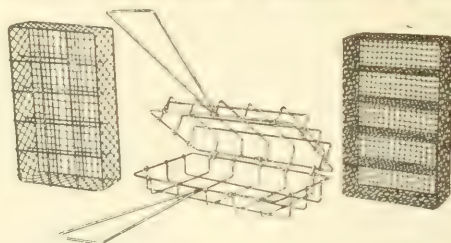
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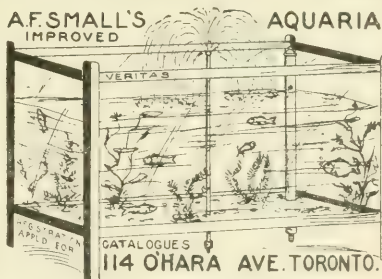
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Voi. X.

TORONTO, AUGUST, 1916

No. 2

Editorials

A NEW HOSPITAL UNIT

THE Government decided a few weeks ago to form a new Hospital Unit, to take the place of what has been known as the Military Hospitals Commission. The

new command will be a duly established branch of the Canadian Expeditionary Force, but will confine its work chiefly to the care of convalescents on their arrival in Canada. The work of the Military Hospitals Commission has grown so of recent months and will doubtless be greatly increased in the future on account of the expected heavy casualties when the British make their long-delayed advance. The new Unit has been constituted by Capital Order-in-Council for the purposes of administration, discipline and command. It will include ten divisions, one for each military division in Canada. In each hospital or convalescent home there will be an officer and subordinates having direction of its affairs, subject of course to the general jurisdiction of the Central Commission in Ottawa. The new Unit will be under the command of Lt.-Col. Sharples of Quebec, who has been in charge of the Depot for Returned Soldiers there. The unit will co-operate with the Army Medical Service in the arrangement and discipline of the various institutions and for the purpose of medical attendance on the men. It is expected that the work of this new organization will have very beneficial results in preventing cases of hardship and distress among returned soldiers.

NEW HOSPITAL ASSOCIATIONS

THIS journal has repeatedly advocated the formation of hospital associations in various sections of the continent; and we are pleased to note that such associations are being formed.

The Catholic sisters, many of whom are precluded from joining with and attending outside associations, are forming societies of their own. Quite recently State of Ohio hospital workers met in such convention. Canada had an active association until the outbreak of the war, when its annual meetings were dropped. We trust that with the close of the war the Canadian Association will revive and continue its good work.

Philadelphia has a society which has done some good work, particularly in studies of hospital efficiency. Meetings of New York superintendents effected a marked improvement in out-patient work, and in dividing the city into ambulance districts, thus preventing much overlapping.

Other states, sections, and cities will organize in the near future, and hospitals, both local and at large, will reap advantage.

REFLECTIONS OF A MEDICAL TEACHER

THE address of Dr. W. J. Councilman, delivered before the Medical and Chirurgical Faculty of Maryland, and reported in the issue of the *Journal*

of the American Medical Association, June 24th, makes very entertaining reading; and contains some good advice.

During a period of many years as a teacher of medical students in the subject of pathology, he has had an abundant opportunity of studying and sizing up the medical student.

The average American boy of 15 is not so well trained as the same aged German boy. There is a lack of thoroughness and evidence of too much assistance in obtaining knowledge, and a lack of independent initiative and self-direction.

The average American boy has not been trained to observe well, and lacks in ability to express himself clearly and with facility. His handwriting is indistinct and without character.

On the whole, students who have taken the A.B. degree are better men than those who have not secured it.

In choosing their life-work, students—to Dr. Councilman's regret—are not aiming at becoming teachers. There is great scope for teaching and research in medicine, and these should go together. The amount of research, as instanced by the massive reports issued from time to time by certain universities and institutes is not an index of the value of work done.

Speaking of the handicap many university professors are under who receive small stipends, the essayist considers that it would be better if the uni-

versities were planted in a wilderness, where there would be an absence of social distractions and a removal of the temptation to any professors' wives to spend their hard-earned salaries on superfluities. Outsiders might be charged an admission fee if they wished to come and live in this Utopia.

Concerning the various fields of endeavor open to varying types of medical students, the writer facetiously refers to that class "whose work will be exclusively in the care of that 20 per cent. of the public for whom illness is often a sad pleasure, practitioners who understand inherited constitutions, fat reduction and high finance."

Dr. Councilman lays much stress on laboratory work. The lecture, of course, has its place as a mental recreation and a stimulant. Some lectures have aspects which are not usually regarded as assets—those with the power of inducing gentle, refreshing, noiseless sleep in the audience. To one who is a poor sleeper there comes a great satisfaction in seeing sleep descending upon an audience. The lecturer experiences an exhilaration at the demonstration of the possession of a power which makes him akin to the God "Who giveth His beloved sleep."

We commend this valuable address to our readers.

THE AMERICAN MEDICAL ASSOCIATION

THE meeting of the American Medical Association, held in Detroit in mid-June was a marked success. The registration amounted to some 4,500. The largest meeting was held in Chicago some years since, with an attendance of over 6,000.

The programmes were good in all sections. Every doctor is not allowed the opportunity of reading a paper at this big meeting—only a select few, and these by special invitation. Our readers who are interested may secure all the papers by subscribing for the journal of the Association, which is published in Chicago.

A sprinkling of medical men from Canada appeared. There ought to have been more. From Toronto we noticed Dr. H. B. Anderson, President of the Ontario Medical Association; Dr. R. A. Reeve, Ex.-Pres. of the British Medical Assn.; Dr. W. H. B. Aikens, President of the Toronto Academy of Medicine, and Dr. Chas. O'Reilly, former superintendent of Toronto General Hospital. Dr. O'Reilly and Dr. Anderson were guests at a dinner given by Canadian medical alumnæ practising in Michigan.

A radium society was inaugurated at the meeting, with Dr. W. H. B. Aikens as first chairman.

The hospital section, though advertised in the earlier prospectuses of the Association, did not have a meeting. It has become defunct. Last year at San Francisco a mere handful of medical superintendents

were in attendance; and the attendance at Minneapolis the year before was not large.

The hospital section of the American Medical Association was a short-lived one—existing only some three or four years. It presented two or three creditable programmes.

This section appealed, of course, mainly to doctors who were hospital superintendents. Most of such doctors are members of the American Hospital Association, to which they have given fine allegiance. Most of them doubtless felt that one meeting a year was all they could find time to attend, and that meeting proved to be the meeting of the Hospital Association rather than the hospital section of the big medical gathering.

THE TREND OF THE PUBLIC HEALTH

RECENT statistics regarding the public health of inhabitants of Great Britain and United States afford interesting comparisons and give food for reflection.

In both countries the so-called infectious, or communicable diseases, are on the decrease relatively, and the degenerative diseases—diseases of the cardio-vascular renal systems are on the increase. Great Britain has a lower rate of mortality in these vascular and kidney lesions than United States.

It is gratifying to note that the death-rate from tuberculosis is gradually lessening; and there is some hope for considering that the prediction of one of

to-day's well-known physicians, that tuberculosis will be stamped out within fifty years, may be fulfilled.

Decrease in the death-rate from diphtheria may be certainly attributed to the use of antitoxin, and to greater care in carrying out isolation and quarantine measures, together with the observance of medical asepsis. The lowering of mortality statistics in scarlet fever and measles may be put under the second category.

The increase in degenerative disease is due to the swiftness of the pace at which the modern city dweller lives, to the use of alcohol and tobacco; and to the poison of syphilis.

Business competition, the race for wealth, and ambition for higher social rank, the desire of educating the children; the hurry, excitement, the noise and bustle of modern city life, all tend to make father and mother old before their time. And age here means premature senility—a disease of arterial degeneration, due to nerve strain and intestinal toxemia.

The remedy for these untoward conditions is education. To education, we doubt not, the British owe their record of suffering less from degenerative diseases than we. The Britisher goes later to work than his American brother, works with more deliberation, takes more time at his meals, can break off for a cup of five o'clock tea (an ordinary right in the London hospitals), goes in more for sport and walks. Whoever sees anyone in America on a walking tour? This is a common sight in England.

Our schools might do more in the way of education in public health. Instead of so much anatomy and physiology, more talks on how to live—how and what to eat and drink, how to sleep, exercise, bathe, attend to eyes, ears, teeth; necessity of frequent hand washing; cleaning of houses, rooms, clothing, dishes; avoidance of infection, and other simple procedures which go to promote high health and lessen disease.

THE MEDICAL PROFESSION: THEIR RELATIONSHIP TO ESTATES

IN the multiplicity of duties devolving upon the medical profession, one of the most delicate concerns the confidential relations towards patients who seek information in moments of emergency as to the appointment of executors for the care or disposal of their property.

Members of the profession are only too familiar with the human tendency to procrastinate in the settlement of personal affairs, until sickness or accident make it imperative that they receive immediate attention—often under circumstances when the presence of relatives, or lawyers, cannot be secured.

The attitude of the profession is rightly strict upon the subject and has been jealously guarded, but events, especially those arising out of conditions created by the war, have directed the attention of medical bodies to the difficulty of the situation.

Happily in Canada a course is open, which, while meeting a patient's necessity, will enable the profession to place the matter in skilled hands and which is not in any way open to the suggestion of ill-advised interference.

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Original Contributions

HOSPITAL EFFICIENCY FROM THE STAND- POINT OF THE EFFICIENT EXPERT*

BY FRANK B. GILBRETH, PROVIDENCE, R.I.

YOUR Chairman, Dr. Codman, in asking me to come here to-day desires, as you can see by the title selected for me by him, that I shall tell you just exactly what an unprejudiced and trained observer in the field of waste elimination thinks of the hospital problem, and just what method of attack upon it he would advocate.

It is necessary, first of all, for me to state what an efficiency expert does and plans to do, and, in the second place, to state just what hospital efficiency is from the standpoint of waste elimination.

Now, an "efficiency expert," so-called by everyone except the "efficiency expert" himself, is simply an engineer who prefers to substitute accurate measurement for personal opinion, judgment, and unscientifically derived conclusions, and who has devised units, methods, and devices of measurement which enable him to measure and compare the factors of results of problems which have been put before him. He is not a man who comes to you with any ready-made conclusions which are the result of theory only, but is rather a man who comes to you with measuring means for comparing any performance with its plan. You, whatever your interest in the hospital problem, whether you are doctors, or surgeons, or superintendents, or trustees, or heads of nurses' training schools, or any others interested in the problem, are primarily scientists. You are interested in facts and the underlying laws which the facts illustrate. All science is based on measurement, and you, above all people, know what we owe to science and to measurement. The prob-

*Delivered before the Boston Medical Society.

lem, then, simply resolves itself into this: In how far has measurement been applied to hospital work in all its branches, and in how far have the results of measurement been taken as actual standards for practice? How can we consider the hospital as a factory, and what methods of measuring efficiency in the manufacturing establishment are usable in a hospital?

In considering hospital efficiency, there are two main factors which must be observed, two questions which must be asked. The first is, "What does this factory, called a hospital, manufacture, that is, what is the hospital aiming to do, and how is it going about to attain this aim?" The second question is, "Are you getting the product as cheaply, as well, as quickly, and in as large quantities as is possible, or as you should?"

Now, hospital efficiency may be stated in many sorts of terms, but to consider the hospital in the most general terms it must be considered as a "happiness factory." The hospital is subject to all the laws and processes of obtaining efficiency in the manufacturing establishment. The output of the hospital or the manufacturing product of the hospital is Happiness Minutes, and the aim of the hospital is to give the largest number of units of happiness to the most people, with the least expenditure of time, of money, and of effort; or, in other words, with the least expenditure of energy possible.

We have to think of this product of happiness in a twofold way:

1. We must think of the happiness of mankind as a whole, that is, of the social group, of everyone concerned.
2. We must think of the happiness of the individuals comprising the group.

Now, the happiness of the social group will be best gained by having each individual in the group happy, and by having all these individuals working together for the good of the whole. In the factory this condition is called "Hearty Co-operation." It is one of the nine fundamental features of measured functional management, and is most carefully planned for and maintained by laws scientifically derived from experimental psychology.

There is nothing that corresponds to this in the present management of any of the scores of hospitals that we have surveyed. The problem is not one of medicine or surgery. It is simply a problem of management. I do not expect you to agree with me to-day. If you do not agree with me, I suggest that you write down what you think the purpose of a hospital is. It is not at all important that we agree among ourselves to-day as to what the fundamental aim is. The important thing is that the aim be determined accurately by a process of unbiased analysis and measurement, and that we have in mind that we must determine as exactly as possible at the start the subject matter of what we are trying to accomplish.

Let us grant for the moment that I have stated the aim correctly. The next question is, "Are we getting what we are aiming for?" No matter what your statement of the aim may be, have you determined to what extent you are succeeding in doing what you want to do? Individual surgeons and hospital superintendents have said, "Yes, we have, and we are perfectly satisfied." But, if you have, have you put your results into such form that others may use them in a definite process of the transference of skill, and that all interested in hospital activity may start in to improve upward from the results of the best and most successful? Granted for a moment that, as a group, your hospital force with all its members and different lines of activity is getting what it desires to as great a degree as possible, how about the individuals comprising the group? Is each doctor, nurse, worker, and patient getting as much happiness out of his work as he can? Is he doing as efficient work as he can? Now, each man is most efficient when he does that work which he can do best, and likes to do best, for the greatest per cent. of his time possible. The social group is doing its most efficient work when every member of an organization has been given this type of work, and has been relieved of all other types of work, such work being given to those specially fitted to do it, and delighted to do it.

It is not my desire to offer any but constructive criticism in this paper; but I feel sure that I am not going too far when I say that *no* hospital has as yet submitted its aims and its methods to accurate measurement, and that most hospitals have

not put that work which they have done in such form that it can be effectively used by other hospitals.

"But," you will say, "it is easy to say that the hospital should determine its actions by accurate measurements. Just how would we go to work on the actual application?"

First of all, then, by applying the survey principle, by recording exactly *what* you are doing, and *how*, and, as far as possible, *why*. It is not my intention to attempt here, as I could, to tell you what is done in applying the principle of waste elimination, or Scientific Management, to the industrial establishment; to translate and to adapt this work to hospital practice, and to tell you what has actually been done in the field of hospital work. It is simply my intention to show you in broad outline that the underlying methods of waste elimination, obtaining of standards, teaching, and transferring of skill are applicable to all fields of activity. It must be stated here, then, that the first step in all improvement is a most careful, painstaking, and accurate record of present practice. But where is there such a record? We have been trying for three years to get some surgeon to write a detailed account of an operation! This work of recording is not to be lightly regarded, for it lies at the foundation of all permanent and self-perpetuating improvement. It is no secret process. It is not work requiring a most expert knowledge of the trade, or even an expert knowledge of how to make a survey. It is work which requires a fundamental analysis of the problem, and an absolute determination to submit everything *just as it is* for an accurate, lasting record that shall be unprejudiced, disinterested, and scientific in the highest sense of that term. A preliminary elementary study may well take the form of supplying answers to the simplest of questions, such as, "*What is done?*" "*Who does it?*" "*Where is it done?*" "*When is it done?*" "*How is it done?*" "*Why is it done?*" Are you willing to submit everything in your hospital to this searching questioning, to lay the full record, as taken down, before yourselves and each other, and to work out the solution from there? That is the great question to answer, and, if you answer, "Yes," to this, the entire solution of the problem is simply a matter of keeping at the work.

The next step following the recording is applying the measurement to the records. Naturally, such measurement is technical work. In order to do it, you must understand the fundamentals of management, and you must apply the various tests which have been worked out, and which apply to capacity of all sorts. It is right here that you must realize the likenesses which underly all lines of activity. If this century is going to be great for anything, it will be because so many of the men of to-day have the scientific attitude of mind, are willing to put aside prejudices, and parallels, and platitudes, and misbeliefs, and standardized blunders, and look at things as cold-blooded measurement shows them on the chart. It has been customary always to emphasize the difference between things. This is the day to look for the likenesses as well as the differences. The great fundamental thing underlying all lines of activity is the fact that it is human activity, and that the study of the human being, the way he moves, the way he thinks, the things that influence him, the things that he influences, and his decisions underly everything that he does in every field. Physiology, psychology, sociology—the study of man in his various aspects, in his various activities—these lie at the base of it all.

You are a surgeon. You handle instruments. You operate on human beings. Are you willing to say that you handle tools, that you work in a plant, that you have a product? You are a hospital superintendent. Are you willing to say that you work in a plant, that you route material, that you direct functionalized workers? You are a hospital trustee. Is it apparent that you must aim for a standardized product, waste elimination, a "paying investment"? "Yes," but you say, "Why think of these things in these terms? Why bring out the comparison to the industrial plant? Our work is different, is greater." Or, as one doctor said to me, "We don't need efficiency so much as you do in a factory, because when we need money we just go out and get it." "What is there to gain by using the industrial vocabulary?"

Simply this, the industrial world has been obliged, through economic pressure, to go into the field of waste elimination; and, because it has been obliged to go, has gone; and, because

it has gone, has worked out underlying laws for attaining least waste, underlying methods for applying these laws, most fundamental of all, a realization of the importance of measurement and an equipment of units, methods and devices of measurement that make waste elimination possible. The results of our investigations show conclusively that you, with the greater need and the greater education and the greater field and the work of greater importance, can gain results from measured functional management, the magnitude and far-reaching effects of which no industry could hope to equal.

You have but one thing to do, to see and accept accurate measurement. What has been done in the industries is at your service. You, as individuals, are, or should be, taking these results and going to work at your own problems, but the big things cannot be done until you go into this science as a group, ready to work each in his own line and all together for the increased efficiency of the hospital. Functionalization, inspection, standardization, the right incentive, the proper teaching, the least fatigue, the greatest welfare—these are the results. At the root of them all lies this one thing, *measurement*. It is the solution of the problem of hospital efficiency. Time study, motion study, the chrono-cyclegraph, and micro-motion processes, all these are means of making measurements that lie ready to your hand. The one great preliminary question to be answered is, "Shall we make the hospital a place fit for scientists to live and work in? Shall we submit our work to measurement and act on the results?"

War Hospitals

THE CANADIAN ARMY MEDICAL SERVICE

No branch of the Canadian service has done more heroic and beneficial work in the present war than the Canadian Army Medical Service. Unheralded and unsung, the men who wore the sign of the Red Cross have carried out their duties, and thousands of men will return to Canada when, with less care and attention, they would be sleeping in a soldiers' grave. Under the expert guidance of Surgeon-General G. L. Jones, the system of dealing with the wounded and sick has been perfected, so that now from the time the brave soldier is struck down by the enemy he is accorded the best of attention and care until he is once more fitted to take his place in the world. Many stories of heroism could be written of the stretcher-bearers and medical officers who, undaunted by the battle raging about them, recover the wounded, render whatever aid is immediately required, and start them on the road to recovery. The splendid devotion of the Canadian nursing sisters is also a source of great pride.

In Russia, France, Belgium and the Mediterranean, wherever the Allies are to be found fighting, the Canadian Medical Service is represented. With the Russian forces the Dominion is represented by one nursing sister. Canada has supplied 4,320 beds and 1,264 officers, nurses and men to the Mediterranean Expeditionary Force. No. 7 Canadian Cavalry Field Ambulance is serving with the Indian Cavalry Corps. The total personnel in the various fields is 6,935, comprising one surgeon-general, ten colonels, 48 lieutenant-colonels, 93 majors, 458 captains, 21 lieutenants, 723 nursing sisters, and 5,528 non-commissioned officers and men. The total bed accommodation is 14,963.*

Major D. A. Clark, of Toronto, realizing how anxious Toronto people must be regarding the care of their loved ones at the front when they are wounded, prepared the following, showing how Canadian casualties are dealt with:

*These figures were correct at date of writing, but now may be subject to revision.

Every soldier carries in a special pocket in his tunic an emergency bandage; this is applied immediately on receiving the wound, either by himself or a comrade.

As soon as possible a soldier is got to an advanced dressing station. This is a concealed spot—a hole in the ground, an old cellar, or any place suitable and concealed from the enemy's fire. From there he is picked up by the field ambulance, which approaches during the night to the nearest possible point. Further dressing and treatment is given at the field ambulance station (usually two or three miles behind the firing line), and as soon as possible the casualty is conveyed to the casualty clearing station, and then by ambulance to a stationary hospital or one of the general hospitals at the base. The advanced points deal with all soldiers of the Allies regardless of nationality, race, or color, the first consideration being prompt attention to the injuries received.

On the arrival of a soldier at the base, or any intermediate points, if the injuries are trifling, and he is going to be well within three weeks, he is sent to a convalescent company or a convalescent camp, and returned from there to his fighting unit. Other cases are transported, at the earliest possible moment consistent with safety, to hospitals in Great Britain. There are about 1,500 active treatment hospitals, of which the only Canadian ones are:

The Daughters of the Empire Hospital for Officers, 1 Hyde Park Pl., London.

The Duchess of Connaught Canadian Red Cross Hospital, Taplow, Bucks.

Moore Barracks Hospital, Shorncliffe.

The Ontario Military Hospital, Orpington, Kent.

Shorncliffe Military Hospital, Shorncliffe.

Beachborough (Queen Alexandra Canadian Hospital)—under Imperial control, but supported by Canadian War Contingent Association.

Soldiers are received into all these active treatment hospitals independently of the regiment to which they belong (nationality or color), so that a Canadian soldier may be in any one of the 1,500 hospitals.

For some months after the beginning of the war, in order that soldiers might be near their homes, transfers were allowed to be made from one hospital to another on the consent of the officers commanding the respective hospitals. It was found, however, that this necessitated a very great amount of work on account of the number of these transfers, that the whole service was being clogged, and the transporting of wounded soldiers from overseas into hospital was seriously interfered with by this internal congestion. It was, therefore, decided that these transfers could only be carried out under the direction of the deputy director of medical service of each respective command, and the consent of this officer must now always be obtained before any transfer can be carried out.

Canadian soldiers are again gathered back under the control of the Canadian service in the Canadian convalescent hospitals, and all Canadian soldiers on their discharge from active treatment hospitals must be sent to a Canadian convalescent hospital. These are:

Bearwood Park, Wokingham, Berks.

Canadian Convalescent Hospital, Bromley, with its beautiful annex of Kingswood, Dulwich, a house standing in thirty acres of land, originally the home of Johnston Levis (Bovril), a well-known Canadian, and now completely furnished and equipped to accommodate ninety convalescent Canadian soldiers, and maintained wholly at the expense of the company and its staff.

Hillingdon House, Uxbridge.

King's Canadian Red Cross Hospital, Bushey Park.

Convalescent Hospital (Canadian Section), Woodcote Park, Epsom.

And into these all sick or wounded Canadian soldiers are gathered. From these they are sent forward as soon as possible to the Canadian Casualty Assembly Centre, Folkestone, where they appear before a medical board, and are disposed of in accordance with their physical condition.

In addition to this system of hospitalization there are special Canadian hospitals for treatment of particular conditions. The West Cliff Canadian Eye and Ear Hospital, Folkestone, takes care of all cases of injury or disease of the special senses; the

Granville Canadian Special Hospital looks after all cases of bone injury, of injury to nerves and joints, cases of shell shock, and special cases requiring electrical treatment. The work of these two hospitals is among the very finest in England, and the results obtained are not excelled by any hospitals in the whole service. Colonel Courtenay of Ottawa is the officer in charge of West Cliff Hospital, and Colonel Ward of Winnipeg of the Granville Canadian Special Hospital, while Major Russel of Montreal is the consultant on nervous conditions (the work of this officer has been particularly brilliant.) There is also a special hospital at Buxton for the treatment of cases of rheumatism, and especially fine results are obtained there.

On the arrival of a soldier at the Canadian Casualty Assembly Centre after leaving a convalescent hospital, he appears before a medical board, and is classified as—

Fit for duty.

Fit for temporary light duty requiring physical exercise and training to become fit for duty.

Fit for temporary base duty, or

Fit for permanent base duty.

Discharge from the service and invalided to Canada.

Those soldiers requesting their discharge in England, if they are recommended for such, are brought before the Pensions and Claims Board, Bath, and their case is disposed of, but no soldier is allowed to be discharged in England till he has produced adequate documentary evidence that he will not become a charge on the British public.

In the case of soldiers who have received injuries to limbs necessitating amputation, the procedure of hospital treatment is the same until their arrival at a Canadian convalescent hospital. As soon as they arrive there, if they are sufficiently recovered, instead of being sent forward to the Canadian Casualty Centre, Folkestone, they are transferred to the Granville Canadian Special Hospital, Ramsgate. At this hospital, as soon as the stump is ready for measurement, the representative of the Artificial Limb Company, from Queen Mary's Auxiliary Hospital, Southampton, sees the soldier and makes the necessary measurements and casts for the artificial limb. The soldier either remains at Ramsgate pending the completion of his limb, or, if

he has friends in England, may be given furlough until this is ready. Upon the completion of the limb at Roehampton the soldier is transferred to the King's Canadian Convalescent Hospital, Bushey Park (which is near Roehampton), and from there driven over daily in an ambulance to Roehampton for fitting of the limb and practice in its use. When he becomes partially expert he is transferred again to Ramsgate, and his training in the use of the limb completed there. Queen Mary's Auxiliary Hospital, Roehampton, is the hospital specially set apart for the manufacture and adaptation of artificial limbs for all soldiers of the British service who have suffered the loss of limbs.

Blinded soldiers are sent to St. Dunstan's College for the Blind, Regent's Park, London. This is one of the most beautiful residential colleges in England, is under the direction of Sir Arthur Pearson, and every comfort of these cases is studied and attended to there. These patients are particularly bright and cheery, and in no way reflect to the ordinary visitor the serious loss they have sustained. They are trained to various trades and useful occupations, such as chicken raising, basket making, typing, massage, piano tuning, book making, etc., and are, of course, instructed in the Braille System and every method of reading and writing of the blind. A more delightful spot cannot be found in England, and more thorough training for these cases cannot be found in the world.

An idea of the extent of the work of the Canadian medical service may be gained from the fact that during the week ending June 24 the number of Canadian soldier patients in hospitals in England was over ten thousand.

The matter of artificial eyes is dealt with at Westcliffe, where an absolutely complete series of eyes (all sizes and colors) have been supplied by the leading British manufacturer and greatest artist in this somewhat restricted field of art, so that an exact copy of any can be promptly supplied, and these are given in duplicate to provide for any accidental loss. This was largely the work of Colonel Courtenay.

EPSOM HOSPITAL IS UNIQUE

"On the road to Epsom." The phrase recalls the thousand-times-pictured carnival of Derby Day, when the four-in-hand of the aristocrat jostles the light cart of the Lambeth tinsmith. A very different kind of traffic goes along the same road in these present months. Made up mostly of slate-colored ambulances, it leaves the route for the racecourse soon after the pleasant little red-tiled town is passed, and pulls up on one sweeping shoulder of the Downs, where the largest convalescent hospital in the United Kingdom has come into being.

There are approximately four thousand beds for sick and wounded soldiers in this hospital. Fifteen hundred are Canadians, who are housed in their own special division. A thousand or more patients are from the Imperial forces, and the rest of the population of invalids consist of Australians and New Zealanders. In its elements, therefore, the thousands in this city of wounded and sick soldiers are a replica of the millions in the battle-line.

Frankly, the proper title for this settlement is Woodcote Park. The surroundings thoroughly deserve such a pretty name. The huts of corrugated galvanized iron have brought the term "Tin City." To be honest, this is the name by which it has been dubbed for the moment, and is justified when a view is taken at close quarters. Not the least disparagement is intended. Rather the other way, for the name of "Tin City" is an indication that the Government which designed this big plant has been alive to its opportunities in gathering material the most easily convertible for the object, and putting it to use in an environment which of itself will do wonders in helping to make sick and wounded soldiers strong again.

Surgeon-General Kilkelly, C.M.G., M.V.O., surgeon of the Grenadier Guards, is in command of the entire hospital. The Canadian division is commanded by Major L. E. W. Irving, D.S.O., of Toronto, and is divided into two sections known as Woodcote Park section, and Farm Camp section. Captain D. A. Murray, of Toronto, is in charge of the Woodcote Park section (500 beds), and Captain Goulden, of Winnipeg, of the

Farm Camp section (1,000 beds). Other officers of the Canadian division are: Captain H. R. Thomas (Toronto), Adjutant and Transport Officer; Captain H. Bell (Collingwood), Registrar; Captain Duck (P.E.I.), Paymaster; Captain G. P. Howlett (Ottawa), Medical Officer; Captain Tait (Vancouver), Dental Officer; Captain the Rev. W. B. Carleton (Ottawa), Chaplain. Sergeant-Major A. Pegg (Ottawa) is regimental sergeant-major.

Whatever mistakes have been made in the British conduct of the war, nobody has yet brought any charges of neglect against medical forces established in the United Kingdom. Woodcote Park, like every other hospital here, English or Canadian, is—as we expect—perfect in resources and organization. No need, therefore, to dwell on these points. More interesting is it to review the special character of the treatment given to the patients, which reveals how the war has brought into play initiative and enterprise in the medical no less than in other branches of the service.

Woodcote Park is for patients who have been discharged from active treatment hospitals, and are convalescents, but who need a course of physical training, adjusted to each patient's ability and physical condition, before they are fit to return to the fighting units. The wounded or sick soldier comes here for a stay of six weeks for treatment, discipline and physical training. Besides severe disabilities, there may be others which are slight in themselves, perhaps, but which make it impossible for a man to return to the ranks as an efficient fighter. In addition to a staff of trained sergeant-instructors in physical exercise, there is at Woodcote a staff of masseuses.

Massage is often a prime remedy for such disablements. Women workers, incidentally, are also found in several other departments. All the cooking, for example, is done by women, for whom a special line of huts has been built. Graduated route marching, to fit in with the condition of the patient, is another feature of the treatment—not the deadly slog in the sweltering sun which we associate with the training of a recruit, but a steady, gentle exercise which brings no exhaustion, and which will cause the man who partakes in it to feel that on each day's marching he sheds some little of his old hurt.

There is, too, a grand assistance of the surroundings of the hospital to be reckoned in the curriculum of the treatment. A look over the Downs from any point of Woodcote Park is in itself a first-rate tonic. With such a panorama to gaze upon, a patient would be justified in apostrophizing nature with the same ecstasy as did Mr. Pickwick at Dingley Dell. The patients are going to emulate the Dingley Dellers this summer in vanquishing All Muggleton at cricket. Football matches against local clubs have already provided great sport. Baseball is played regularly, and all forms of sport are encouraged to get the men back into "fit" condition. Every night there is a first-rate theatrical show or concert. Lord Killanin, who is resident in the hospital, takes great interest in the entertainments, and devotes his whole time to this for the benefit of the patients. The recreation hall comfortably holds an audience of 1,500, and is provided with theatrical and cinema equipment.

In the establishment of Woodcote Park one beholds an enterprise hitherto unattempted in the medical service of the Empire. The main object, it is seen, is to save hardened and experienced soldiers from being "scrapped" on account of obstinate ailments for which a remedy may be found in special treatment. When one considers the length of time and expense incurred in fitting a recruit for the firing line, it will be realized that the truly skilful management of resources lies in assisting him, should he be disabled, to regain his position in his battalion. This, of course, apart from the obvious benefit to the man himself in regaining his full strength. The Government and the officers connected with this institution, therefore, deserve our gratitude to the full.

Western University Hospital Corps

THE First Contingent of the Western University No. 10 Hospital Corps left for the front on June 19th. The doctors and the rest of the unit left a few days later, the corps' organization having been completed in record time. This unit is under the command of Lieut.-Col. (Doctor) Seaborne, of London, Ont.

The King's Canadian Hospital, Bushey Park

Six wings of the King's Canadian Hospital at Bushey Park have been completed and furnished by the Canadian Red Cross Society. Each wing will bear the name of one of His Majesty's children. It was hoped that Their Majesties would perform the opening ceremony, but they found it impossible to do so, being unwilling at the present time to appear ceremonially, preferring rather to make visits to the hospitals after they are fully established.

Another Hospital for Canadians

Lieut.-Col. Johnson, of Charlottetown, has been detailed for duty with the Canadian Medical Stores in France. Major Guest, of St. Thomas, succeeds him as Commandant of the Convalescent Hospital at Buxton, which is already open and nearly holding its full capacity of three hundred suffering from rheumatism and like ailments.

The accommodation of the Canadian Section of the hospital at Epsom has been increased by a thousand, making the total 2,500. It is instended shortly that Epsom shall be devoted entirely to the Canadians, which will give 3,800 beds.

The following have joined the Canadian Army Medical Corps; Dr. Pratt, of Stratford, Ont.; Dr. R. D. Sanson and Dr. Bishop, of the Calgary General Hospital; Dr. Gauthier, M.P. for Gaspe; Dr. J. L. Seibert, of Stratford, Ont.; Dr. Egerton L. Pope, of Winnipeg.

Mr. Harold Kennedy, lumber merchant of Quebec, who has already placed the Bromley Hotel at the disposal of the Canadian Medical Service as a Convalescent Hospital, has now acquired an estate near Maidstone for the same purpose. The mansion is a particularly fine one. The estate comprises five thousand acres.

Canadian Hospitals

NEW ONTARIO HOSPITAL FOR THE INSANE AT WHITBY

ON July 11th a new era in hospital work in Canada was started. It witnessed the beginning of the end of an undertaking which when completed will have cost in the neighborhood of a million and a quarter dollars, and will be the finest thing of its kind, not only on this continent, but excelling anything in Europe, a proud boast for Ontario.

To be explicit, on July 11th, the first patients went into the new hospital for the mentally ill, which has been under erection by the Government for the last two or three years on the lake shore in the heart of the country adjacent to Whitby, and which will supersede the Toronto asylum for insane in Queen Street West.

As different as day from night are the new surroundings for the mentally ill from the building they have occupied for so many years. It is the difference between iron bars and the freedom of green fields.

Representatives of the daily newspapers were motored to the new hospital property of 650 acres near Whitby, to see the buildings, under the guidance of the men directly responsible for the achievement, before the patients began to move in. The Hon. W. J. Hanna, Provincial Secretary, who has a fund of practical sense combined with his "vision"; the Deputy Minister, Mr. S. A. Armstrong, with his genius for carrying out a tremendous undertaking down to the smallest detail; the architect, Mr. Govan, who has worked out to such perfection the hospital buildings, with Dr. Forster, head of the hospital for the mentally ill, made an inspiring group with whom to go over the hospital. And every member of the visiting group left late in the afternoon with a profound admiration for the achievement and a keen realization of the value of the new institution, with its perfect surroundings.

To set down the story of genius and its inspiration-bearing fruit is a part of the duty of these words.

To tell not of man's inhumanity, but something of man's dear humanity to man is another part of what I would try to convey here. All of which sounds a bit in the clouds when, after all, it is a practical story of bricks and mortar, combined with that blessed thing, a man, or men, with a vision, who confidently step out into untried places and achieve things worth while.

We have always glibly spoken of the lunatic asylum, or asylum for the insane in Queen Street West. As we have passed the high brick walls surrounding the grounds and building it has been with more or less of horror if our thoughts dwelt on the people behind those walls. They have seemed to us something apart from human beings. It was as though there were wild things caged up there, things which might excite a morbid curiosity, but which were removed from us more effectually than if they were in their graves. To know that eight or nine hundred lives were being lived there had something of the horror of a nightmare.

This has been the attitude for generations towards the people who in reality are just mentally ill, as you or I might be physically ill. Some—many—are curable, just as in physical illness. Others become chronic—as in physical illness. And just as you or I know of our illness, so many of those mentally ill are conscious of the fact. And it is only modern grasp of the situation which is calling them, not insane, not lunatics, but people ill mentally.

Dr. Forster, in charge there, can tell you of many people, who have gone to him voluntarily to be treated in the asylum. Their agonized query is, "Doctor, am I insane?"

"No," is his answer. "You are mentally ill," and the agony and horror in their minds is relieved by the more human—and truer statement. For as the doctor says, "We hope to prove that ninety per cent. of the cases of mental illness are curable."

But to get back to the building. Some four or five years ago the present property in Queen Street West (which is quite inadequate for the demands), was sold to the railway. Im-

mediately the Provincial Secretary and his Deputy Minister were on the lookout for suitable property on which to build the new institution.

They did not look in the city.

Why?—Because a moment's thought will make one realize that the city is not a place for a hospital to treat jangled nerves and minds. It needs the country, with its quiet, its pure health-giving air. And so it was that 650 acres of land was purchased not far from Whitby, and plans for the hospital buildings were made and the work of building began, a certain portion of which is now completed and ready for occupation. It should be a matter of pride with Canadians that this new institution in construction and equipment and sanitation is superior to anything modern scientific effort has produced. New York has been watching the development in which scores of original ideas have been introduced, with keen interest. One of the leading American electrical journals is running an article on the perfection of the lighting system as worked out here by the men we all know, while the kitchen equipment has revolutionized such things for all time in institutions.

A few of the outstanding facts might be given before attempting to picture the place. Of the 650 acres, over 300 was swamp land three years ago. Now 550 acres are under cultivation and the most modern methods of farming introduced have resulted in bumper crops of potatoes, vegetables, hay, grain, etc. The men working the land have been men from the prisons, men who in days gone by would have been spending time inside prison walls, adding viciousness to their natures, and being an ever-growing expense to the community.

The produce of this property has helped to provide other Provincial institutions with food. And on the same principle of making these Provincial institutions self-supporting, instead of a burden to taxpayers, prison industries have provided practically everything but the raw material for the new buildings. From the red tiles of the roof and the tile stairs of an original design made at the prison industry at Mimico, to the doors, window sashes, tables, iron beds, mattresses and even to blankets, almost everything has been produced by prison labor, at a cost which would not have begun to cover the expense, had manufacturing industries throughout the country done the work.

Not a dollar has been spent on useless adornment. Everything is planned for the spending to the best advantage, every single cent. To prevent waste in any way many ingenious ideas have been evolved which will help to revolutionize equipment of institutions.

The buildings are absolutely fireproof, so far as scientific ingenuity can make them. Sanitation has been one of the outstanding features. There are no corners. Floors meet the walls with a cove. Everything is washable. Non-corrosive metal has taken the place of wood in cabinets or shelves for clothing. Practically everything from the very garbage cans in the basement to the snow-white equipment in the diet kitchen will be sterilized.

Now to give some idea of the property and buildings. Picture a square mile of typical Ontario country. Orchards, country roads, great fields of clover and hay, corn, fields of small fruits, rows of beautiful old spruce trees, the property running to the shores of Lake Ontario. Vision the green fields, the blue waters, the little Whitby inlet with its quaint lighthouse. Catch the fragrance of clover and of new mown hay. And see in the midst of all this, buildings beautiful in their simplicity, giving the impression of groups of lovely country homes.

Of course the majority of the buildings are still incomplete. And when the building is done, will come the making of terraces and lawns, surrounding the buildings.

We speak of buildings in the plural—not of one monster building. According to the plans there will be something like 25 when they are completed. But those in which at present we are particularly interested are the groups of "cottages" for men and for women patients which form the big part of the colony. The nurses' residence, the chapel, the amusement building and others are still seen only on the plans and in the loads of bricks.

The cottages for women, of which there are eight, all identical as to both design and architecture, and each with accommodation for from 50 to 60 patients, are so far complete, that to-day one cottage was occupied by fifty-five patients. To-morrow another fifty-five will follow until all are occupied.

The group of buildings for the female patients is a complete hospital unit, and is identical with a similar group for the male patients. Besides the eight cottages, each a complete hospital in itself, the group of buildings includes a completely equipped infirmary building, and the separate building for dining-rooms and kitchen equipment. Here is a separate dining-room for each cottage, so that the classification of patients as arranged in the cottage may be obtained. In this building also is the nurses' dining-room, the maids' dining-room, and "the last word in scientific kitchen equipment."

To give any concrete idea of the kitchen equipment is almost impossible. The man in charge here is one who for years has specialized in elimination of waste, and on correct diet. He is a man with a continent-wide reputation.

The entire huge kitchen and serving corridor with its white tiled floor and walls, its metal serving tables, its dish washing machine (in which 12,000 dishes can be washed and sterilized in an hour by the efforts of one person), its miracles of meat-cutting machines, potato masher and peeler, its monster soup caldrons, its polished steel tables, and its economic system of steam cooking, must be seen to be appreciated. Two thousand meals a day will be served in the kitchen, and twice the number could be handled. One's great wish in seeing these things is that manufacturers might also see the wonders of scientific saving accomplished, and might realize what can be done here in Canada.

There is, of course, complete refrigerating system. Even down to the detail of a special sink arranged to catch the scales from fish cleaned there, nothing has been overlooked.

The dining-rooms are more attractive than one often sees at the most exclusive summer resorts. The nurses' dining-room opens on to a wide balcony, giving them opportunity for privacy and rest at their spare time.

To return to the cottages. You get an excellent idea of the exterior from a northerly viewpoint. It is of brick and stucco. The construction is of hollow concrete reinforced with metal. Everything is fireproof, and nothing over two storeys in height. And here is something interesting. "Can you allow the patients to wander about the grounds?" was asked of the doctor.

"They will always return to a place that looks like a home," was his answer. Surely that was an illuminating fact in the comfort and happiness these places promise.

Each cottage has three day rooms, fitted with wide brick fireplaces, lighting and plumbing, which cannot be tampered with by patients, complete diet kitchen, metal fitted clothing room, bath for therapeutic treatment if patients become excited, airy and attractive, sunny wards, so arranged as to be easy of observation by the nurse, wide verandahs, head nurses' rooms, etc.

The day rooms are most attractive, the walls finished in light buff and Quaker grey. The best of furniture, great fire-side benches, chintz hangings, and bright rugs help to make the rooms attractive. The floors are all either tiled or covered with ship linoleum.

Such is a very incomplete picture of the new hospital colony for mentally sick people, who stand an infinitely better chance of being cured in such surroundings and under scientific treatment than could ever be the case in the present asylum.

The value of outdoor work, never possible in the old quarters, will be apparent here, where there is every opportunity to give the exercise which will help to restore normal conditions. And for those who can never get well, there is a place beautiful to dwell in, removed from the curious gaze, from the exciting noise and from the narrow quarters in the city. After all God's sunshine and pure air are the greatest gifts, and man's best gift is a "home." All these and more are bequeathed to the mentally sick, fortunate enough to be housed in the new colony hospital near Whitby.—Helen Ball in *Toronto News*.

The Executive of the Hamilton Recruiting League recently decided that special provision should be made for caring for returned soldiers, and that the new Mountain-top Hospital, when completed, be used for this purpose.

Kootenay General Hospital at Nelson, B.C., is to be reconstructed and greatly enlarged.

Dr. Howard Black has been appointed Assistant Superintendent of Toronto General Hospital.

It is proposed to enlarge Tranquille Sanitarium, B.C., so as to accommodate three hundred patients.

Cobourg General Hospital held its first commencement recently, when ten nurses received their diplomas.

The Lady Minto Hospital at Cochrane is now completed, and was formally opened on May 24th.

The City Council of Brantford submitted to the ratepayers on June 26th a by-law for \$58,000 for Hospital extension.

The graduating exercises of the Training School for Nurses at Wellesley Hospital, Toronto, were held on Wednesday, July 5th. A reception followed afterwards.

Dr. John Hicks has been appointed to succeed Dr. J. J. McFadden as Superintendent of the Brandon Insane Asylum. He was formerly Assistant Superintendent.

The Isolation Hospital at St. John, N.B., was recently destroyed by fire. Fortunately, there were no patients in the building at the time.

An Isolation Hospital has been opened at Lindsay. The Dominion Government made a grant of \$10,000 toward the purchase of the site.

Major J. A. Dixon, of Hamilton, Medical Officer of the 91st Regiment, Canadian Highlanders, has joined the Royal Army Medical Corps, and has left for England.

A Nurses' Home is to be built on the western side of Calgary General Hospital, and will be connected with the Hospital by a passage. It will provide accommodation for one hundred nurses.

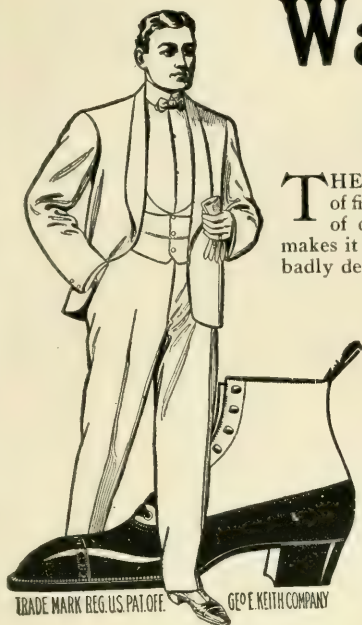
Dr. Kidd, Medical Superintendent of the Hospital for the Insane at Cobourg, has been appointed Assistant Medical Superintendent at Brockville, and will have charge of the new Reception Hospital for Nervous Diseases there.

The annual commencement exercises of the Kingston General Hospital Training School for Nurses took place recently, when the announcement was made of a legacy of \$10,000 from the estate of the late E. H. Schmerhorn, of Napanee. It is intended that the money will be used in enlarging the Nurses' Residence.

The new head of the Toronto Orthopedic Hospital, succeeding the late Dr. B. E. McKenzie, is Dr. W. S. Verrall, formerly of Vancouver. Dr. Verrall is a graduate of the Faculty of Medicine, University of Toronto, and has recently been in practice in Vancouver, though he specialized in orthopedic surgery.

Toronto's New Military Base Hospital

A FEW days ago the new Military Base Hospital, reconstructed out of the old Toronto General Hospital, was announced ready for occupation, and Lieut.-Col. T. B. Richardson and staff moved in, feeling grateful for the relief from over-crowded quarters at Exhibition Grounds. There is no doubt that the new hospital was urgently needed, there being at the time of removal nearly 550 patients at Exhibition Camp. Lieut.-Col. Richardson has been formally promoted officer commanding, with the following as his staff: Captains H. H. Harvie, B. L. Gingall, J. W. Livingstone, R. D. Mackenzie, A. A. Campbell, Colin Campbell, C. E. Treble, H. E. Wallace, C. C. Ballantyne, R. F. Slater, James E. Barry, F. G. Wilson and A. E. Macdonald.



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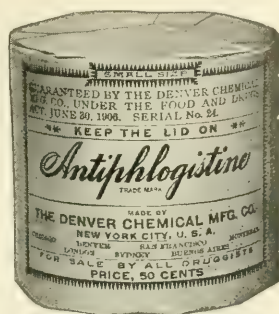
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ABDERHALDEN TEST IN MENTAL DISEASES

CHARLES E. SIMON, Baltimore, (*Journal Amer. Med. Assoc.*), takes up the claims of Fauser as to the findings of the Abderhalden test in certain types of insanity, with special reference to dementia precox. He reviews the literature which followed Fauser's publication, and says that in surveying it one cannot help but be impressed, on the one hand, by the wonderful uniformity of the results reported by Fauser and the wide divergence from those of certain other authors, like Hauptmann and Bumke. He thinks that there is good ground to suspect that Fauser was too enthusiastic in his views and also that his opponents may have lacked complete control of the technic. Fauser himself states that he obtained a reaction with sex gland repeatedly in cases in which it was unexpected, and that the diagnosis between maniac depressive insanity and dementia precox could not always be made with certainty. Simon relates his own experience with the use of the test in 106 cases and says "to summarize the results" that a sex gland reaction may be obtained in nearly if not all cases of dementia precox at some stage or another, but that this action is not specific, as Fauser asserts. He finds that the reaction may also be obtained in other forms of insanity, and he does not attempt to explain them. He must, therefore, conclude that Fauser's rule has exceptions or that the positive findings in manic-depressive insanity or paresis are due to errors of diagnosis or technic. The fact, however, remains that in dementia precox the positive reaction is the rule, while in the purely functional psychoses it is the exception. Simon, therefore, discusses at length the technic employed and which he thinks meets fairly any criticism from the technical point of view as far as our knowledge goes at present. He believes, however, that advances can still be made, and while we cannot, as yet, draw positive conclusions regarding the significance of the reaction in dementia precox, certain possibilities suggest themselves. One of these is that of a perverted function of the cells concerned in the production of the internal secretion of the sex glands in dementia. "Considering the problem from the clinical side, the all-important question, of course, suggests itself whether or not the reaction has any relation to the pathogenesis of dementia precox. Theoretically, this is, of course, perfectly possible. Granted that anti-sex gland ferments do occur in the circulation in dementia precox, and that their presence were the outcome of the appearance in the circulation of an abnormal secretion or of abnormal cells, then we may also assume that digestion of these cells or cell-products will take place, and that all conditions would thus be given for a chronic protein intoxication which might very well expend itself on the central nervous system. Should this be true, then we might also expect that the administration of sex gland to such patients would cause an aggravation of the patient's condition, while partial or entire castration, possibly combined with the transplantation of normal organs, might similarly be expected to have a beneficial influence.

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CHRONIC irritation by coal oil products is considered by B. F. Davis, Chicago, in the *Journal Amer. Medical Association*. Irritation from coal oil products was first discussed by Volkmann in 1875, who described an acute and a chronic form. The final stage is thus described by him: "As a result of individual predisposition and particularly deficient cleanliness, the process, which previously has been a hyperplastic epidermic growth and sebaceous secretion, now develops into multiple, warty or papillary formations, some of which degenerate into cancer." In some cases the sebaceous crusts described above exhibit almost a horn-like consistency. The chief seat of these hyperplasias are the exposed forearms and the scrotum. In an old workman Volkmann counted fifteen such warty growths with thick crusts on the dark-brown spotted and fissured forearm, and three on the scrotum. This picture of warty growths completely suggests the "verruca cancerosa" of the aged. Schamburg tabulated reported cases up to 1910 and remarked on the tendency to undergo spontaneous involution. Many of the lesions ulcerate and destroy themselves. The source of the tar seems to have an influence. In Great Britain gas works tar causes dermatitis, while blast furnace tar does not. One explanation is that gas works tar contains substances capable of producing cell division *in vitro*, while blast furnace tar does not. The irritating substances seem to be present in crude paraffin as bodies having possibly an amidine nucleus and associated particularly with the compounds of the anthracene group. The greater portion of them are probably separated from the oil in the pressed distillate process. Davis reports a case from Dr. Bevan's clinic and describes the conditions found by him in an oil company's plant where the crude paraffin is run into great presses and the oils, pressed distillate, extracted. The paraffin remaining in the press and presumably containing the irritating substances is scraped off by the men, who have their arms smeared with the substance. During the first few months the majority suffer from "wax boils" on the arms and neck and in some cases it develops into true epithelioma, as in the case reported. Closely allied to this form of cancer is the so-called tobacco cancer, the cancer of aniline dye workers, of chimney-sweeps and kangri burns of the natives of Cashmere caused by the little portable heaters that they carry under their clothing. Irritation by heating cannot, however, be considered as the cause of most of the other forms, and none other than a chemical cause seems possible, in the tumors of aniline workers and the betel-nut workers. Davis concludes that it seems justifiable to assume that the paraffin cancer is from chemical irritation and the other forms may also have the same cause.

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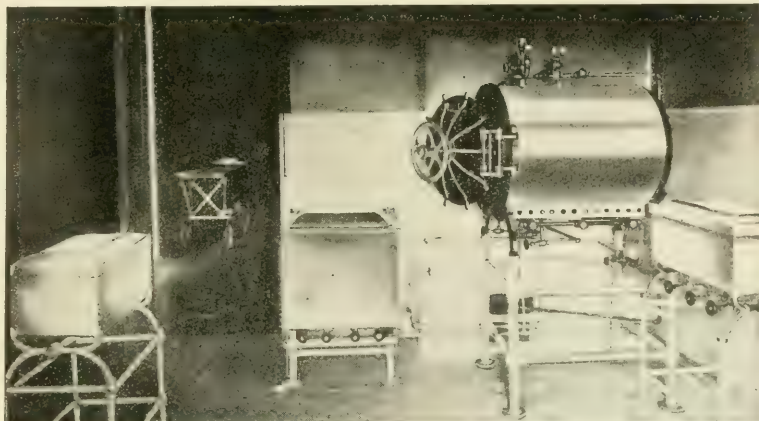
Refraction of the Human Eye and Methods of Estimating the Refraction. By James Thornington, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic and College for Graduates in Medicine. Philadelphia: P. Blakiston's Son and Co., \$2.50.

Dr. Thornington has here amalgamated into one volume, three of his former works, "Refraction and how to Refract," "Prisms," and "Retinoscopy," and has certainly thereby added to their value and popularity. For the medical student and the medical practitioner beginning to take an interest in practical ophthalmology, one cannot too highly recommend this book on methods of refraction.

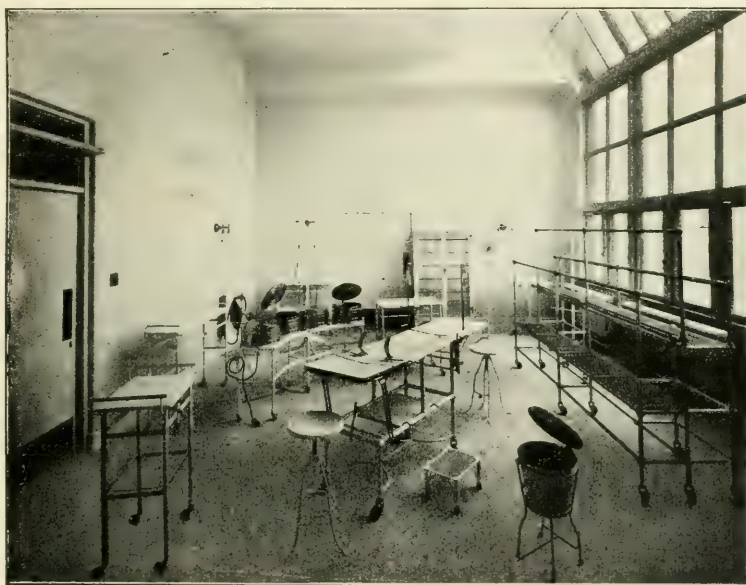
The Description of an Ophthalmoscope. Being an English translation of Von Helmholtz' "Beschreibung eines Augenspiegels." Berlin, 1851. By THOMAS HALL SHASTID, A.B., M.D., Chicago—Cleveland Press, 1916.

To every oculist this translation will be, and to every physician should be, of the greatest interest. It does not at all detract from the fame of that great physicist, Von Helmholtz, to say that in 1847, Babbage, an Englishman, devised an instrument for seeing the interior of the eye, which contained the essential features of the ophthalmoscope, as later devised by Von Helmholtz.

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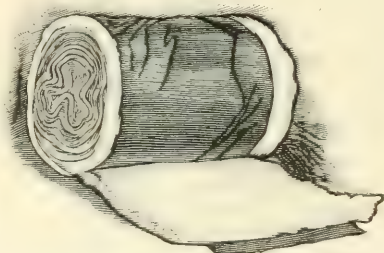
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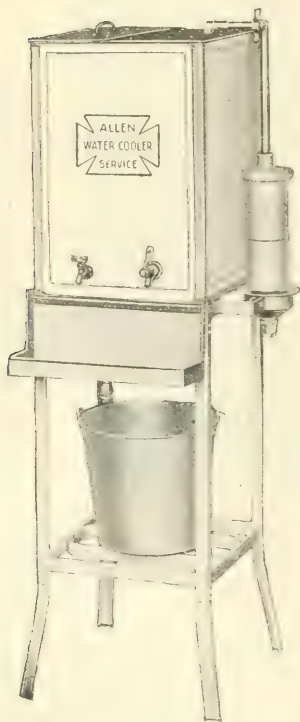


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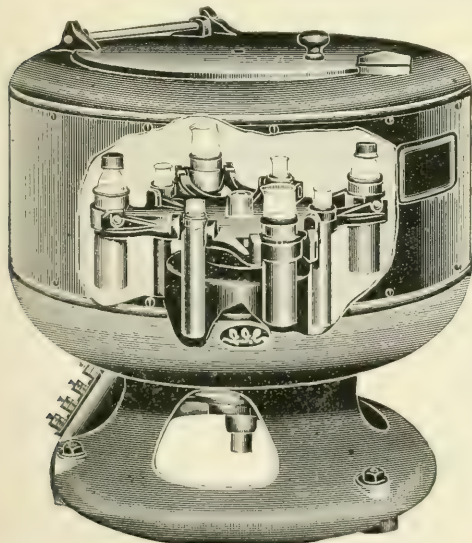
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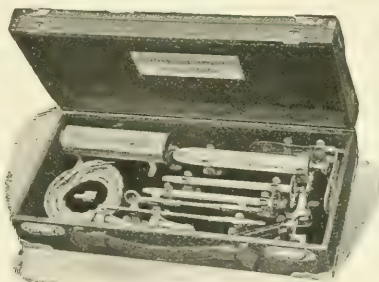
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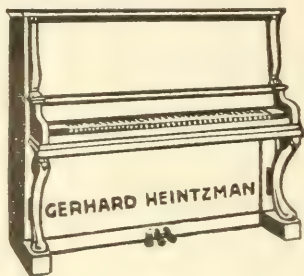
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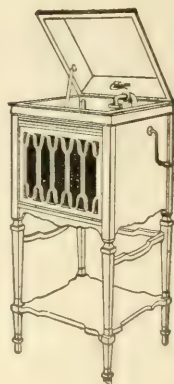
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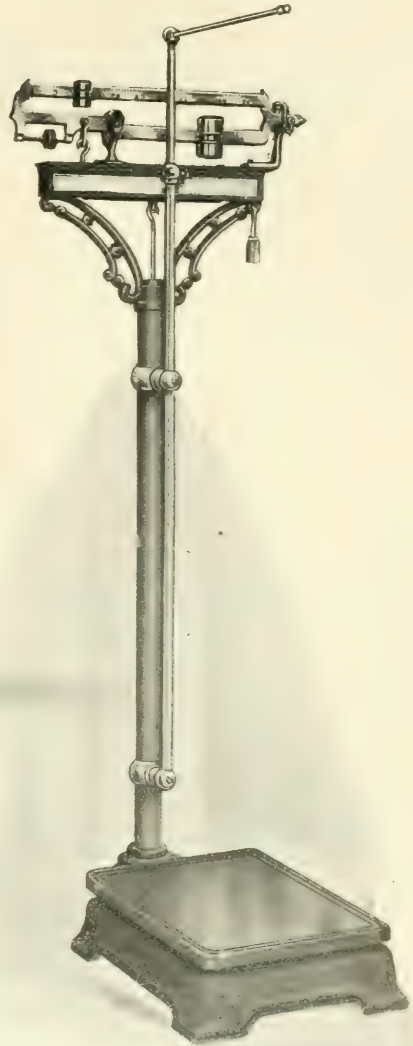
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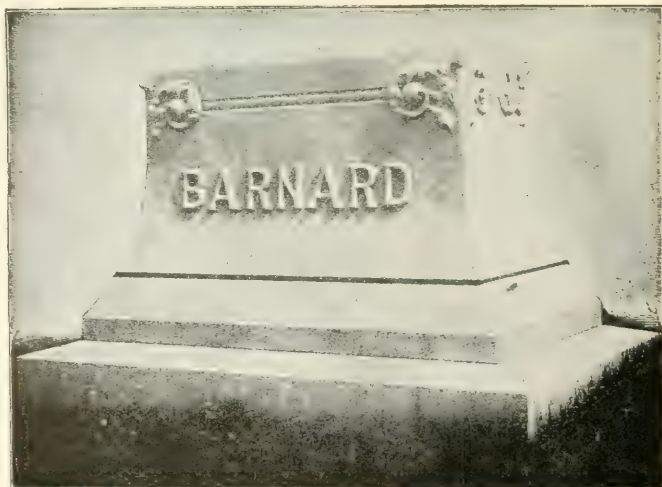
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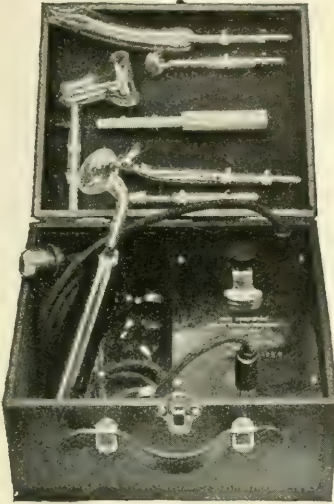
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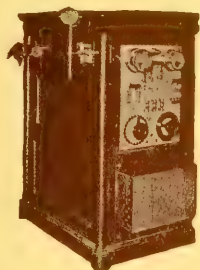
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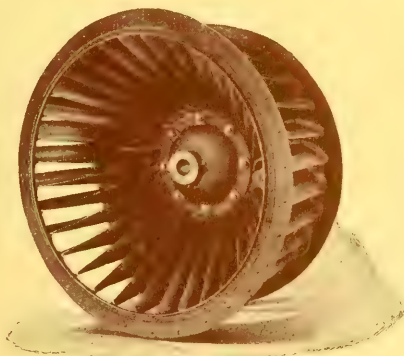
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THE HOSPITAL WORLD

Vol. X (XXI)

Toronto, September, 1916

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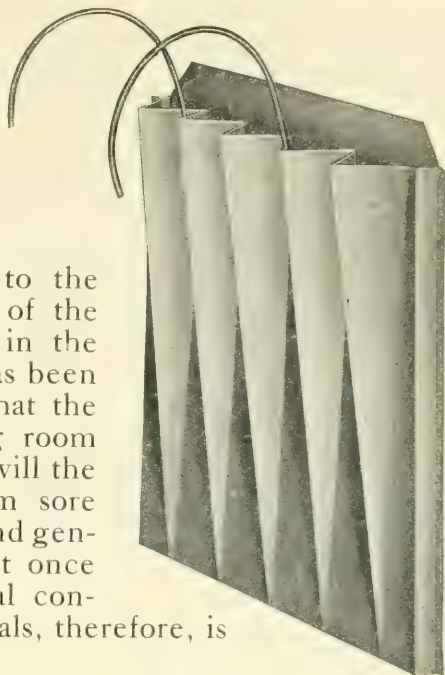
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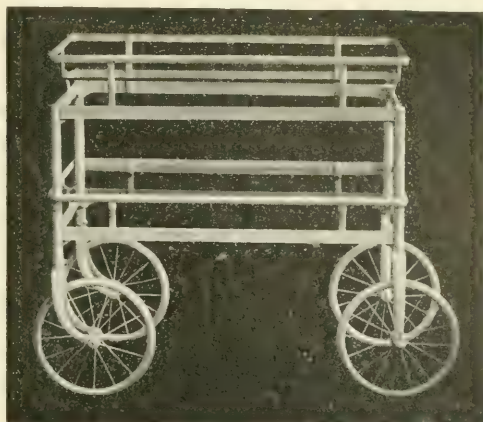
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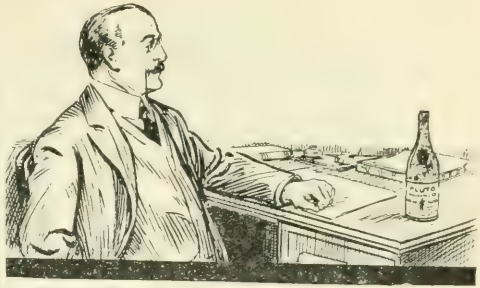
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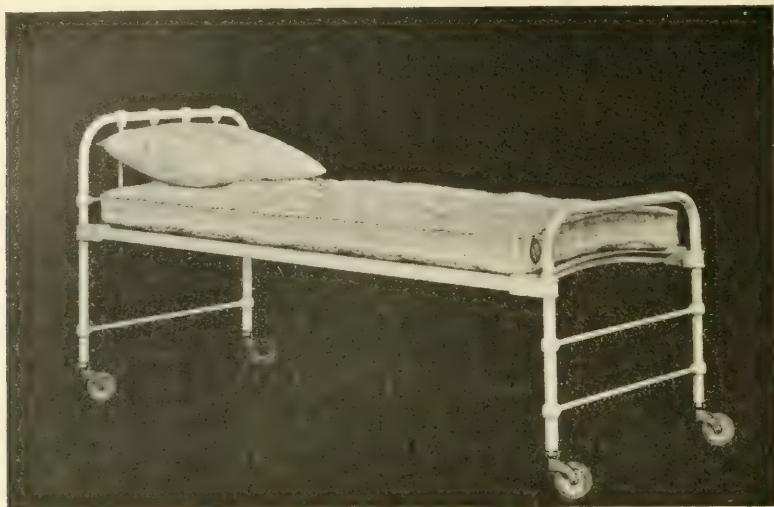
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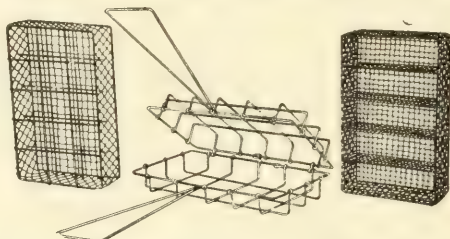
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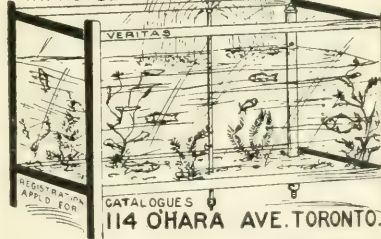
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Voi. X.

TORONTO, SEPTEMBER, 1916

No. 3

Editorials

THE RESTORATION OF DISABLED SOLDIERS

THE therapeutic treatment and re-education of our disabled soldiers are making progress hand in hand under the painstaking and enlightened policy of the

Military Hospitals Commission. Some of its Institutions are, naturally, doing a larger and more varied work than others, but the Commission is evidently determined, as far as possible, to bring them all up to the highest standard of efficiency.

The aim of this truly national work is to secure for every man disabled in the service of his country restoration to active and useful citizenship—restoration as complete as medical and surgical science can make it, with the co-operation of all the social and moral forces available.

The degree in which success is achieved in this effort will be the degree in which we shall avoid the national disgrace of having a class of men among us reduced to the necessity of living on other people, or on their pensions alone, without doing their utmost to support themselves.

At the Federal Commission's Hospitals and Homes, and in other Institutions co-operating with them, we have men already improving themselves in such subjects as elementary English, French, writing and arithmetic, book-keeping and mechanical drawing, telegraphy, carpentry, wood carving, light metal work, clay-modelling and toy-making, with vegetable and flower gardening, poultry raising and bee-keeping.

One of the most important steps lately taken for the improvement of the system is the adoption of a time-table, sufficiently elastic to meet the greatly varying needs of the individual inmates of Military Convalescent Hospitals, and at the same time com-

prehensive enough to provide, under medical supervision, occupation of some kind or other for the whole of the time. The danger which this is calculated to prevent will be obvious enough to all our readers.

LINE UPON LINE

So much has been said and written about the necessity of pure milk supply that the subject has become too trite to hold the attention of the general public. Even the medical profession is inclined to dispose of it as a platitude. Yet every summer emphasizes the truth afresh and every hospital and sick room realizes how long a step has yet to be taken before perfectly pure, clean milk, and only such, becomes the common and only commodity of its kind in the market.

There are dairies and dairies, of various degrees of merit, some openly unfit and dirty, some—and these are most to be dreaded—making pretence of cleanliness by outside show; while others, as yet in the great minority, are struggling with more or less success to measure up to the standard that ensures a safe, pure product.

There are notable dairies in this respect, and certain points in their conduct are worth noting.

Special breeds of cows, such as Holsteins and Guernseys, produce very fine milks which may be mixed without injury to the flavor of either. These cows, should, of course, be proved free from tuberculosis by the tuberculine test. They are stalled in

clean, well-lit, well-ventilated stables in preference to pasture fields. The most up-to-date dairies have a lounging barn, clean, sanitary and bright, like the stable, and bedded with plenty of fresh straw, which is constantly being removed for farm manure and replaced with the clean article.

Between the barn and stable is a cleansing pool in which the sides and shoulders and udders are laved preparatory to milking. Electrical milkers are preferably used, the milk collected in closed sterile containers, and immediately taken to cold storage and kept cool until consumption.

Naturally, milk thus prepared will cost more than that now delivered at the majority of hospitals; but it should be worth the value to the sick, since the guarantee of such richness and purity means so much in the process of building up the enfeebled body.

Such conditions as related are neither fanciful nor ideal. They exist in some of the modern dairies of the continent, and are being widely copied.

By-and-by these best things in milk production will become general conditions, and as such become the source of milk supply for the average citizen at a cost within the reach of the average wage-earner. No other will or should be tolerated.

But the education of the people in this as in other health reforms is slow.

COOLING ROOMS

A LEADING hospital in New York has recently provided an especially cooled room for pneumonia cases—the practical outcome of which innovation has yet to be announced.

The recent protracted spell of intense heat which was so hard to endure in the hospitals, both by patients and staff, brings up the problem of making provision for cooling hospital wards and offices. It is taken for granted that many private wards are supplied with electric fans; but this does not solve the problem for the public wards, since the majority of hospitals do not feel that they can afford to provide fans in sufficient quantity for the large wards, or the cost of their continuous service. Awnings, of course, mitigate the heat somewhat.

Hospitals having the plenum system, by which the heating and ventilating are provided by the same process, can always obtain cool air. In addition to the pumping in of washed air, which affords a good deal of cooling, the incoming air-stream may be drawn through a chamber partly filled with ice. To such hospitals as are provided with fan intake this procedure is to be recommended.

In the future it may be possible to provide local refrigeration in large wards somewhat on the same principle as that now employed by the John Manville Company in the compact little apparatus in which the refrigeration is produced by sulphur di-oxide.

Original Contributions

CONCERNING THE ARCHITECTURE, CONSTRUCTION AND ERECTION OF THE HOSPITAL KITCHEN AND THE EQUIPMENT OF SAME

BY VON INGENIEUR HITZLEE, WÜRZBURG.

Translated by RUDOLPH BAUMART from *Zeitschrift für Krankenstätten*.

WHENEVER an architect is called upon to submit plans for the installation of a complete kitchen for any kind of an institution, it is necessary to obtain, first of all, information regarding the space required, the equipment and all the installations needed, as well as the most economical and practical arrangement of such apparatus.

The usual method pursued for gaining such information is generally obtained through the study of already established kitchens in full operation, and in absorbing the experience and knowledge of the management of institutions which are operating such kitchens and have gradually solved and overcome such problems as may have presented themselves from time to time, in the endeavor to place the operation of this part of the institution on a highly efficient basis. It is further customary to ask for complete working plans and specifications of kitchens from firms manufacturing kitchen apparatus. This method of investigation will invariably result in the return of as many different opinions and theories as the interested party has asked for. Such conditions, however, will be encountered not only in cases of this kind, but will prevail more or less wherever technical specifications for complete equipment of large institutions have been required.

The ideas regarding the number and size of the main working rooms of the complete kitchen of a large establishment differ greatly. For reasons of economy and easy management, one

large general room, sufficiently equipped, is found, in many instances, wholly adequate for all practical cooking purposes, to which may be connected a small diet kitchen for short orders, wherever required.

In other institutions, again, one will find that the culinary department is desired to be of complicated construction and divided into various sub-departments. In the latter instance separate rooms are demanded, e.g., steam cooking, frying, milk, so-called diet and cold service kitchens; a separate kitchen for physicians and patients of the first class, as well as one for the nurses. There can be no doubt that such divisions can be of practical value only if applied to organizations of the first magnitude where the so-arranged different sub-departments come under the supervision of already installed sub-department heads.

The decision regarding the application of any specific system should be governed, naturally, by the character of the institution in question, which may be a sanatorium with only one system of diet (or none at all—that is, to install a kitchen for the sake of completeness or emergency only). Again it may be an orphans' home or an establishment for the care of the old and poor; or it may be a hospital where in-patients, as well as out-patients, are treated, special attention being given to an elaborate system of variegated diets.

All these technical points, as well as the psychological and financial conditions under which the proposed kitchen will have to operate, should be perfectly clear before a decision as to the number and size of rooms is attempted. Such foresight will not only secure the right number and (for the required service) correct grouping of rooms, but it will also, in many cases, allow the architect to economize materially in the size and often in the number of rooms required for the purpose. Without this information the contractor will find it absolutely necessary to provide for extra rooms, and also must figure the size of all rooms large enough to take care of a working capacity which may greatly exceed the preliminary estimate.

Opinions regarding the size of such kitchens vary greatly. For instance, the city hospital, St. Rochus, of Mainz, Germany, with a capacity to accommodate 550 patients, has a kitchen covering an area of about 60 square metres; while the city hos-

pital of South Magard, of like size, boasts a kitchen space of about 160 square metres. It is obvious that dietary conditions in these two hospitals must differ widely, otherwise it would be logical to assume this department of one place is much too large, or that of the other much too small; and, of course, either condition would be highly undesirable.

Too small quarters will always appear untidy, are hard to clean and, on the whole, will be found uncomfortable in every direction. The other extreme has also proved itself impractical, requiring too large a working force, and—what should be avoided most—involve not only an unnecessary large capital to construct, but also will exceed greatly what may be called “first practical upkeep expense.” In summing up, it will be comprehensible that one general scheme, covering the practical installation of complete diet-kitchens for any kind of institution, as to size and distribution of rooms, must be considered more or less impossible.

This is true, also, for all auxiliary apartments and its equipment required for the completeness of the former. A hospital, for instance, located in a city where hired help is expensive and hard to obtain, will instal, surely, preferably machinery to do away with the time-killing work of potato-peeling. No doubt this method will insure a certain loss of material. This, however, should be found a negligible factor, as compared to the former, on time and expenditure, so wasteful method. Different, however, are the conditions in a home for the old, or in similar institutions. There are found old women and men who, for the benefit of the home, and even for the sake of their own physical well-being, may be used for general light work. Of course these different conditions will require quarters of different size as well as of different equipment. A peeling-room of the latter kind must be spacious and the workers themselves are best placed on benches around the walls, facing the interior, so they may indulge in harmless conversations, to give interest to the rather monotonous work, but mainly to provide for easy control, which is of importance, for instance, in a sanatorium for the feeble-minded.

The same room where mechanical devices only are to be employed may be much smaller than the one just touched upon.

However, careful provision should be made beforehand for all machines and apparatus to be installed. It is customary to use this room also for the cleaning of all other vegetables. For large hospitals it may be practicable to locate this room next to the potato-storage. Institutions fortunate enough to grow their own vegetables and connected direct with their nurseries, should have the cleaning of vegetables attended to in the nursery, if necessary in a special shed erected for this purpose. This arrangement not only reduces the work of this part of the kitchen, but also eliminates the work of returning the refuse to the so-called "compost-heap" of the nursery. Whatever of this refuse is to be used for the feeding of animals can, of course, be separated and taken care of at the time of cleaning by the gardener or his helper. Some institutions have been found to send vegetables to be cleaned, peeled or dressed to certain wards. In such cases, however, the involved wards should be equipped with suitable quarters for this purpose.

Much simpler to solve are the problems of that department set aside for the cleaning of dishes. On the whole there are only two different conditions to be considered which may influence the size and equipment of this room: either the dishes are cleaned and stored in the different wards, while the room provided for this purpose, the general kitchen, takes care only of the cooking utensils, the vessels used in the transportation of the food to the different wards, and finally the dishes used by the kitchen *personnel* themselves; or all dishes used will be returned to general washroom, usually found next to the cooking department. This latter system will hardly be found practical in very large public establishments, considering the extra work and risk of transportation of the dishes, and wherever found, conditions will or should warrant its application. So, generally speaking, no extra large room is required for this department of a complete kitchen plant. If no provision is made for a special room to store the dishes, it will be necessary to provide for long walls, unbroken by doors and windows, to facilitate the building of shelves for the proper keeping of dishes. However, a special room for this purpose, next to the washroom, is recommended.

The absence of a room for the temporary storing of all refuse and cooked food-remnants is disagreeably noticeable in some kitchens, and makeshift arrangements are resorted to, which spoil effectually the otherwise immaculate appearance of this department. Small box-wagons or barrels can be seen at the entrance of the kitchen, or at the doors of other kitchen departments, with visible signs of spoiled foodstuffs around, its odor generally proving even more offensive than its untidiness. Even in the corridors to the general heating plant or power house could these vessels containing the kitchen refuse be seen. To overcome these objectionable features it is always best to build, in a suitable, little, well-ventilated place, either next to where the just-used dishes are returned, or next to the washroom itself, whichever may be found more expedient, easily accessible for both the storing as well as the cleaning out of the refuse. Whatever establishment has followed this little bit of advice has never found reason to regret it.

Again, the arrangement of those localities used for the distribution of the cooked meals to their various destinations may differ widely. Many institutions, especially those for "psychopathies," or feeble-minded patients and the like, generally believe in the separation of sexes. In such cases there will be necessary a double provision for food-distribution, arranged according to the location of male and female departments. Of course this is required only if the food is received and distributed really by inmates of both sexes. This is, however, not the case very often, and surely not where the establishment consists of several or many separate buildings or groups of buildings. In these cases properly designed hand-wagons may be used to convey the cooked food to the different units; and here only one room for the dispensing of the meals is needed. It may be required, however, that some special prescribed food between regular meals, and ordered for both sexes, will have to be delivered jointly. This work is mostly done by nurses or other suitable institution employees.

Now, then, is the meeting of both sexes at this department really so dangerous to require two separate places of food-dispensation? What will hunt for each other will find each other, and that at occasions which surely are more suitable than meet-

ing at the kitchen at meal times, when the surveillance is or should be the most stringent. The time of delivering meals to the different groups may also be so arranged that such conditions will be eliminated automatically. Regular hospitals, where most of the nurses and other general help are of the feminine gender, only one place for the distribution of meals is needed. For establishments using for food distribution transportation wagons, only one ample, large room is required, allowing these wagons to come near enough to the delivery window to make loading and unloading practical. In connection herewith it may be mentioned that these food wagons, with their *personnel*, should not have to pass through open grounds, subject to all kinds of weather conditions, but be able to make their deliveries to all buildings while protected by roofs always; and further, the transport to the different floors should be mechanical, avoiding the climbing of stairs. It is self-understood that the actual kitchen rooms, including the delivery department, should be separated from that room where the food is received, and connected only through suitable apertures or delivery and receiving windows as the logical points of contact.

[*Note.*—Short paragraph pertaining to dispensing of alcoholic drinks omitted, considering that it recommends the regular use thereof by both patients (if condition permits) as well as attendants. Will hardly receive American sympathy.]

Constant worry and trouble is usually experienced with the storerooms of the kitchen plant. (This does not include cellar or refrigerators, which will be treated separately at another place.) Beans, peas (dry), vegetables, spices, sugar, salt, flour, bread and cakes—in short, all kinds of groceries and mill products generally bought wholesale by the larger institutions—have to be received, checked, and so stored that the goods will not spoil or lose in quality or weight. Furthermore, the storage should be so arranged that any article required at any time can be procured without losing time by the necessity of hunting therefor, or of moving large quantities of other articles to get to it.

Therefore, the rooms provided for storage should be comfortably large, light, dry, and well ventilated. Not overlooked should be the fact that all incoming goods must be properly

checked, by reweighing, remeasuring or recounting, as may be the case, which requires a special receiving-room equipped with the proper paraphernalia, such as scales, measures, etc. This department should have a good size receiving window and space enough to hold in orderly condition a large consignment of groceries just received without confusing the receiving-clerk, and should be in direct connection with the storage itself. Where the latter is located on a different floor, the relative position of the receiving to the storage room should be so arranged that a direct connection can be maintained by the aid of a dumb-waiter. Wherever possible, it will be found very practical to build outside of the receiving-room a protected platform, facilitating unloading, avoiding the spilling and spoiling of goods more or less, which without this last safeguard must be carried through some outside space, no matter how short, with results at least highly aggravating if this happens on a rainy day. Of course it is assumed that the receiving department is located on the ground floor, where it actually should be. Now the entire work of receiving can be done in the storage rooms themselves. However, such practice invariably leads to trouble wherever it is found necessary to reject part or all of the consignment, for the obvious reason that goods returned accidentally will be exchanged for some already in storage, or that this at least is stoutly claimed by the party having delivered such disputed goods.

The subdivision of this kind of storage, according to the different nature of the groceries to be stored, is advisable and required for the same reasons as the division of cellar-rooms, which is discussed at length in a later paragraph.

Beside the real storage rooms, which may be located in the kitchen-building, but by no means should be too close to the actual cooking department, there should be a small room for miscellaneous goods, used at all times, but in such small quantities that they cannot practically be accounted for each day. These special spaces, easily compared to the handy pantry found in all private houses, are absent in kitchens of many large institutions. If such a room is missing, for the care of these small items just mentioned, then there must be for them coffers and chests or cupboards in the cooking or adjacent rooms, where

they do not belong, and take up unnecessary space. It is also impossible to take proper care of such goods in the dark and narrow places provided by these makeshift contrivances. The building in of one or two of such pantries, if possible next to the cooking-room, is highly recommended.

Another very necessary kind of storage facilities are the cellars. Good cellar rooms are found to be of great benefit, sometimes even a necessity, to private houses. This is also true, only infinitely more urgent, for the proper running conditions of complete kitchens of large institutions. The natural demand to place this kind of storage in the basement or sub-basement of the kitchen-building is difficult indeed, considering the hot-water and steam pipes used for the modern kitchen apparatus, such as condensers, steam cookers, etc. The mains of such pipes are generally laid through the basements, and no matter how well isolated, will radiate heat, which slowly but surely permeates the whole basement, preventing the cellar rooms from retaining their natural coolness, which makes cellar storage so valuable in private houses not suffering under these complications.

To obtain the required cellar temperature under the above-mentioned adverse conditions, it would seem necessary to expel the warm air from these cellars and replace it with the required much cooler article by mechanical means; but how can this be done when the outside air is already much too warm for cellar purposes? As stated before, the isolation of the pipes alone does not solve the problem. It has been tried to lead all mains through a special, therefor provided, basement room, insulate its walls and keep the storage rooms as far as possible removed from this so-called "pipe-cellar." But even this method proved futile. The storage cellars could not be used for their designed purpose. This artificial warmth once in the basement is there to stay, and nothing short of the removal of the offending pipes can bring relief. Some benefit has been obtained sometimes by shutting the storage cellar completely off from the other parts of the basement by solid, heat-isolating walls and allow for an extra entrance to your storage, and if possible direct to the outer air. But in this case all other intervening walls must also be heat-isolated, otherwise little joy and satisfaction will be experi-

enced with these cellars. It may be considered highly advisable to overlook the inconvenience and transfer this cellar storage to the basement of some other building in which such offending pipes will not be found. It is further recommended, especially for institutions engaged in truck farming, to build for potatoes and turnips a special cellar direct in the ground. This is the best and natural cellar obtainable. Of course, even in such natural cellars proper provision has to be made for drainage, airing, facilities for easy storing as well as easy delivery of the storage to the kitchen, and in some modest measure also for what lighting may be needed.

Special mention is made here regarding such cellars used for the making and storing of "sauerkraut." Special arrangement must be made for the admission of water for the washing of the cabbage, as well as good drainage for the disposal of all used water as well as the water liberated by the pressing of the "kraut." For the latter purpose certain machinery is required, making necessary extra high ceilings to allow for the unimpeded working thereof. In this cellar extra attention must be paid to the sufficient airing of this room.

The very nature of the articles to be stored in cellars will in themselves demand certain isolations and make easy a decision as to the proper division of the different cellar storage rooms. It is for instance, self-evident that cheese, eggs, fruits, meats or "sauerkraut" cannot be stored in *one* room. Barring other complications, such proceeding would lead surely to one article taking on the taste or smell, or both, of one or more other articles stored in its vicinity. This is one of the *important* things the efficient kitchen manager has to bear in mind in the distribution of cellar storage rooms. The best proof of the above statement is found easily in many small grocery stores, where all goods are piled in an indescribably little space and, to the distress of the discreet buyer, have taken on all kinds of tastes and odors. Even the air of such a store is a conglomeration of many odors characteristic of these stores. Of course, the actual food-value may not be impaired. However, a good superintendent will make sure that all goods retain their own original aroma and peculiarities, and this cannot be done by the dividing of cellar storage by lattice-work or board partitions.

It requires regular old-fashioned brick and mortar, or modern concrete, walls to obtain results.

[*Note.*—Paragraphs on storing and handling of beer and wine and pertaining to making of wine, omitted.]

It hardly requires mentioning that all cellar storages must be absolutely immune to frost.

A very important group are the ice and cooling cellars. Large and even medium establishments will do well to instal a complete mechanical ice-plant, for cooling and ice manufacture, which will be found very economical where the necessary power can easily be supplied by their own power-house. Artificially cooled rooms are required mainly by that space provided for the storage of meats. Cooling facilities are further highly recommended for the milk, butter and lard, eggs, and similar storage rooms. Fruit and conserved articles will need cool storage, and may be included in the above list. However, where the beautiful appearance of long-stored fruit is of minor consequence, a natural cool storage room will suffice.

To provide faultless plans for the building of these kinds of cellars, as far as number and size is concerned, just fit for a later full running development, is extremely difficult. Too many or too large cooling rooms are undesirable, on account of their high building cost as well as their comparatively high running expense. On the other hand, these rooms must not be too small nor insufficient in number if a practical storage of all articles to be cooled is desired. A decision in this direction must be found mainly in considering the conditions governing the buying facilities. In the case of procuring meats, for instance, here it should be known whether meat will be received daily from local or nearby butchers or it is required to buy meat through sources far away; and in this case enough must be procured to last for three to five days, or longer. For reasons of economy it will be found necessary sometimes to unexpectedly place an institution's meat order with some outside concern, where, for instance, the local butchers have tried to take advantage of the daily demand and by agreement have killed healthy competition as far as the establishment in question is concerned. Consequently it would be unwise to shut out the opportunity of breaking such a ring by omitting a meat-storage, while depend-

ing on local daily supply. Conditions are similar in reference to the supply of all other goods which require cooling storage.

The failure of having in the first place provided for a sufficient large cold storage has, in fact, made itself felt very uncomfortably in many institutions. Adjacent to the cold storage rooms should be the room for the complete ice and cold storage plant itself, which should be so installed that easy connections to the power-house may be made, and so arranged that these machines can be made to run or may be shut off, according to demand, and independent of all other machinery. A brand new establishment which, of course, will be hardly operated to its expected full capacity for some time to come, need not instal an expensive complete ice-plant until its need is felt. However, the room must be there, with correct plans which show careful provision for every machine later to be set up in this room. Of course, proper connection should also be provided for during building. Under such conditions a later installation will not be more expensive than if done at the time of building.

The rule expounded when treating the creation of natural cellars for storage of eatables, that all warm air, no matter from what source, must be kept out, does apply more so to the cold storage rooms. In this case it will be also necessary that all walls, ceilings and, under adverse conditions, the floors, are made properly heat-proof. This includes doors and windows, which must be a perfect fit and absolutely air-tight. It is very often impossible to find room for the complete cold storage (plant and rooms) in the basement of the kitchen building. This, however, is not so essential. The most used cold storage rooms, such as used for meats and milk, are better located on an even floor with the kitchen itself. This arrangement will save time, running expense, and greatly facilitate the kitchen routine work. There are no difficulties found in this two-storey arrangement as far as the technical or mechanical side of the question is concerned. Where cold storage rooms are placed even and next to the kitchen, two doors enclosing a small ante-room should be provided to prevent the transfer of hot air from the kitchen to the cold storage, or *vice versa*. Is this ante-room large and light enough, then a few ammonia pipes may be extended into it, and it may be used whenever practical or

desirable for the preparation of meats for the cooking or frying process, as the case may be.

As stated before, for all machinery of the cooling plant, as motor, compressor, condenser, ammonia and ice machines, as well as all auxiliaries, careful survey should be taken that the room provided for each machine is absolutely correct as to floor space, height of ceiling and all other dimensions, allowing everywhere room for easy accessibility and a hall ample and light. To enable the builder to accomplish this, it is highly recommended to first agree upon a certain system or ice plant, and if possible consult a firm of engineers specializing in this class of work.

Another small department to be mentioned in connection with institution kitchens is that of coffee roasting. The size of this room, therefore, of course depends upon the magnitude of the whole establishment, and consequently upon the kind and size of machinery to be installed.

We believe that the above endeavor comprehensively covers all general needs and requirements demanded of a modern kitchen plant of any kind of institution, as far as the space and proper division is concerned.

The furnishing of a choice variety of complete kitchen plans for different kinds and sizes of institutions with given specific dimensions has been abstained from advisedly.

As touched upon before, the conditions governing the management of every institution differ greatly. It is a well-known fact that two establishments of like size and capacity, and apparently demanding like facilities, have in reality nothing in common but their size and, maybe, their line of endeavor, the conditions of which, however, may run in vastly different directions, which of needs influence the handling of every department and the general management and is governed by the principle followed in handling the inmates, the class of inmates itself, and sometimes even by the conditions of its very surroundings. It is, therefore, clear that no cut and dried rules can be conscientiously given; the conditions which will probably govern the later work of a new to be built institution must be carefully taken into consideration by the builder, making full use of his experience, as well as that of unbiased authorities on public

institutions, whose long-time connection with such work makes their advice very valuable. We must strongly advise against the use of ready-made plans for all kinds of institutions, which can be found everywhere for sale in the open market, for reasons stated. Many a management who had adopted such plans has later found ample reasons and time for regret.

The details of full equipment for each kitchen department have not been gone into. These are strongly influenced by the prevailing ideas of the building commission, the architects and the management to be, and last, but not least, by the financial resources of the institution. Furthermore, to offer advice relating to building material and on other purely technical questions would be assuming and highly impractical, especially as our modern industries put on the open market constantly new materials, some better than others, which, however, should be considered by a wise builder, too.

THE 18TH ANNUAL CONFERENCE OF THE AMERICAN HOSPITAL ASSOCIATION, PHILADELPHIA, SEPTEMBER 26-29

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PROGRAMME.

TUESDAY, SEPTEMBER 26, 1916.

MORNING SESSION, 10 A.M.

Invocation, by Rt. Rev. Philip M. Rhinelander, Bishop of Pennsylvania.

Address of Welcome, by the Mayor of Philadelphia.

President's Address, by Dr. Winford Smith, President, Supt. The Johns Hopkins Hospital.

Report of Committee on Constitution and By-laws, by Mr. Richard P. Borden, Trustee, Union Hospital, Fall River, Mass.

Medical Organization and Medical Education, by Dr. Chas. Young, Supt. Presbyterian Hospital, New York City.

Discussion, opened by Dr. L. B. Baldwin, Supt. University Hospital, Minneapolis, Minn.

AFTERNOON SESSION, 2 P.M.

Report of the Committee on the Training of Nurses, by Ella Phillips Crandall, R.N., Exec. Sec. Nat. Organization for Public Health Nursing, New York City.

Report of Committee on Grading and Classification of Nurses, by Charlotte Aikens, Chairman, Editor *Trained Nurse and Hospital Review*, Detroit, Mich.

Discussion.

The Open Door Hospital, by Dr. W. L. Babcock, Supt. Grace Hospital, Detroit, Mich.

Discussion, opened by Dr. J. W. Fowler, Supt. Louisville City Hospital.

Report of Committee on Development of the Association, by Dr. R. R. Ross, Supt. Buffalo General Hospital, Buffalo, N.Y.

EVENING SESSION, 8 P.M.

Symposium on Outpatient Work.

What Dispensary Work Should Stand For, by Dr. Richard C. Cabot, Boston, Mass.

Clinics for Venereal Disease: Why We Need Them: How to Develop Them, by Dr. Wm. F. Snow, Sec. American Social Hygiene Association.

Industrial Accident Cases in Dispensaries: Should They be Accepted? How Shall the Finances be Managed? Speaker to be announced.

New Features in Dispensary Work (Committee Report), by Michael M. Davis, Jr., Chairman, Boston Dispensary, Boston, Mass.

WEDNESDAY, SEPTEMBER 27, 1916.

MORNING SESSION, 10 A.M.

Report of Committee on Hospital Construction, by Dr. Walter B. Ancker, Supt. City and County Hospital, St. Paul, Minn.

Hospitals and Esthetics, by Grosvenor Atterbury, F.A.I.A., New York City.

Discussion, opened by Dr. H. B. Howard, Supt. Peter Bent Brigham Hospital, Boston, Mass.

The Hospital Dietary, by Dr. Elliott P. Joslyn, Associate Prof. of Medicine, Harvard University.

Discussion, opened by Dr. Thomas McCrae, Prof. of Medicine, Jefferson Medical College, Philadelphia, Pa.

AFTERNOON SESSION, 2 P.M.

Large Hospital Section.

Disinfection and Other Practicable Methods of Preventing the Spread of Infection in Hospitals, by Dr. Robert J. Wilson, Supt. of Hospitals, New York Health Department.

Discussion, opened by Dr. Wm. H. Walsh, Philadelphia, Pa.

The So-called Diphtheria Epidemics in General Hospitals: Preventive Measures, by Dr. Clyde G. Guthrie, Associate in Medicine, Johns Hopkins University.

Discussion, opened by Dr. R. R. Ross, Supt. Buffalo General Hospital, Buffalo, N.Y.

Autopsies: Methods of Obtaining Same and Measures of Protecting the Hospital, by Dr. Milton C. Winternitz, Associate Prof. of Pathology, Johns Hopkins University.

Discussion by Dr. Frank Holt, Supt. Michael Reese Hospital, Chicago, Ill.

Small Hospital Section.

Conducted by Miss Nettie B. Jordan, Second Vice-President.

Symposium: The Creation and Management of a Community Hospital.

Paper: The Survey of the Community and the Preliminary Work in Establishing a New Hospital, by Dr. W. T. Graham, Supt. University Hospital, Iowa City, Iowa.

Discussion by E. E. Munger, Spencer, Iowa.

Paper: Organization by the Trustees and Superintendent in the Physical Management of a Community Hospital, by F. E. Chapman, Supt. Mt. Sinai Hospital, Cleveland, Ohio.

Discussion by Martha Oakes, Supt. St. Luke's Hospital, Davenport, Iowa.

Paper: Financing the Small Community Hospital, by Ida Barrett, Supt. Blodgett Memorial Hospital, Grand Rapids, Mich.

Discussion by Lucia Jayquith, Supt. Children's Hospital, Worcester, Mass.

Paper: Building and Equipping the First Unit of a Small Hospital, Ralph Shepherdson, M.A., B.S., Aurora, Illinois.

Discussion by Margaret Robinson, Supt. Jefferson County Hospital, Fairfield, Iowa.

EVENING SESSION, 8 P.M.

Theatre Party, Keith's Theatre. Arranged by the Entertainment Committee.

THURSDAY, SEPTEMBER 28, 1916.

MORNING SESSION, 10 A.M.

Report of the Committee on Bureau of Hospital Information, by Dr. Thomas Howell, Supt. New York Hospital.

Report of Committee on Hospital Standardization, by Dr. John A. Hornsby, Editor *Modern Hospital*.

A Study of Hospitals for the Purpose of Arriving at Proper Standards, by Mr. John J. Bowman, Director American College of Surgeons.

Team Work and Stumbling Blocks, by Dr. Charles A. Drew, Supt. Worcester City Hospital, Worcester, Mass.

Discussion, Opened by Dr. Charles D. Wilkens, Supt. Charity Hospital, New Orleans.

Dental Clinics in General Hospitals, by Dr. Thomas B. Hartzell, University Hospital, Minneapolis, Minn.

Discussion, Opened by Dr. Simon Cox, Supt. New Haven Hospital, New Haven, Conn.

Luncheon, Pennsylvania Hospital, 12.30 to 2.30. By invitation of the Trustees and Superintendent of the Pennsylvania Hospital.

AFTERNOON SESSION, 2 P.M.

Large Hospital Section.

Report of Committee to Memorialize Congress to Place Instruments on the Free List, by Rev. G. F. Clover, Supt. St. Luke's Hospital, New York City.

Report of Committee on Hospital Finances and Cost Accounting, by Dr. A. R. Warner, Supt. Lakeside Hospital, Cleveland, O.

Building the Hospital: Departments and Rooms, by Mr. O. H. Bartine, Supt. Hospital for Ruptured and Crippled, New York City.

Discussion, Opened by Dr. A. C. Bachmeyer, Supt. Cincinnati General Hospital, Cincinnati, O.

Convalescent Hospitals: Methods, Results, by Dr. Fredk. Brush, Supt. Burke Foundation, White Plains, N.Y.

Discussion, Opened by Dr. F. A. Washburn, Supt. Mass. General Hospital, Boston, Mass.

Small Hospital Section.

Conducted by Miss Nettie B. Jordan, Second Vice-President.

Paper: How May a Hospital Superintendent Promote More Scientific Work in the Small Hospital, by Mary Riddle, Newton Hospital, Newton Lower Falls, Mass.

Discussion by Emma Anderson, Supt. New England Baptist Hospital, Boston, Mass.

Papers: How are the Superintendents of Small Hospitals to be Trained? by Annie C. Goodrich, Teachers' College, Columbia University, New York City; Dr. Joseph Howland, Asst. Supt., Mass. General Hospital, Boston, Mass.

Discussion by H. E. Bishop, Supt. Robert Packard Hospital, Sayre, Pa.

Paper: How the Scientific Services May be Standardized in the Small Hospital, by Dr. O. L. Pelton, President Kane County Medical Society, Elgin, Illinois.

Discussion by Joseph Purvis, Supt. Western Suburban Hospital, Oak Park, Illinois.

Round Table: Vital Problems of the Small Hospital, by Katherine Prindiville, Supt. Lawrence Hospital, New London, Conn.; Mrs. Oca Cushman, Supt. Children's Hospital, Denver, Colorado; Margaret Rogers, Supt. Jewish Hospital, St. Louis, Mo.

EVENING SESSION, 8 P.M.

Round Table Session for Large Hospitals. Conducted by Dr. John A. Hornsby, Editor *Modern Hospital*. Any member who wishes to have a topic discussed may suggest the same to Dr. Hornsby.

Small Hospital Section.

Question Box Session. Conducted by Dr. C. D. Wilkens, Vice-President. Those who have questions which they wish to have discussed may send them to Dr. Wilkens.

FRIDAY, SEPTEMBER 29, 1916.

MORNING SESSION, 10 A.M.

Report of Committee on Legislation, by Dr. H. T. Summersgill, Supt. University of California Hospital, San Francisco, Cal.

Treasurer's Report.

Report of Auditing Committee.

The Hospital and the Surgeon, by Dr. S. S. Goldwater, Supt. Mt. Sinai Hospital, New York City.

Discussion, Opened by Dr. John G. Clarke, Professor of Gynecology, University of Pennsylvania.

Report of Committee on Efficiency and Progress, by Dr. George O'Hanlon, Supt. Bellevue and Allied Hospitals, New York City.

Election of Officers.

Report of Committee on Time and Place of Next Meeting.

Adjournment.

AFTERNOON SESSION.

A boat ride down the river and a visit to League Island and the Navy Yard.

An auto trip through Fairmount Park to Valley Forge and Washington's Headquarters during the Revolutionary War.

The Committee on Local Arrangements has also made provision for visits to the U. S. Mint, Independence Hall, Wanamaker's Stores and other points of special interest at various times during the Convention.

Special arrangements have been made for those who wish to visit Baltimore on the Saturday following the Convention, and arrangements are also being made for special rates for those who wish to spend a week-end at Atlantic City.

One of the special features of the meeting this year will be the large commercial exhibit, which will undoubtedly be one of the most instructive exhibits ever presented.

War Hospitals

THE KING'S CANADIAN RED CROSS CONVALESCENT HOSPITAL

WITHIN half an hour's ride from London, England, on the London & South-Western Railway, there lies a spot of intense interest to all Canadians, and to not a few other Britishers as well. It is Bushey Park at Hampton Hill, Middlesex, wherein is the King's Canadian Red Cross Convalescent Hospital. The ideal location is due to the generosity of His Majesty the King in placing this delightful section of his park at the disposal of the Canadian Red Cross Society.

Bushey Park consists of about 1,100 acres, and was in its early days a sporting ground for kings and princes. To-day it has a beauty and indefinable charm of its own. Its magnificent and stately avenue of rich foliage, the long stretches of placid waters in its streams, the herds of timid deer browsing on its rich pastures or gracefully gambolling among the trees, all combine to form a wonderful setting of solemnity, grandeur and repose.

Famous for its magnificent Chestnut Avenue, which is over a mile long and fifty-six yards wide, Bushey Park, when the chestnut trees are in full bloom at the end of May, presents a picture of unrivalled splendor. The low, wide, sweeping branches are then laden with myriads of spiked, white flowers tinged with red, to which the massy dark green piles of foliage serve as an admirable background, and which, falling, powder and bespangle the turf below with countless stars. The sight is one that attracts throngs of visitors, and is well worthy the visit of the King and his entourage on Chestnut Sunday, every spring.

In the enclosure occupied by the King's Canadian Red Cross Convalescent Hospital, the old brick and stone manor house, until recent years occupied by the late Lady Paget, together with the adjoining stables and servants' accommodations, has been transformed into quarters for the administrative staff and wards for the patients.

The dispensary, dental operating room and laboratory, as well as the general administrative offices, occupy new and splendid constructed asbestos-walled huts near the main entrance to the grounds. Similarly built huts, with accommodation for 200 patients, have recently been completed near the main driveway. All the most modern ideas in hospital construction have been embodied in these huts, which are a complete unit in themselves and altogether independent of the wards in the manor. The new wards are large, airy and cheerful in appearance, and will, with the kind consent of their Majesties, be named after the children of the Royal family.

In another section of the grounds a commodious concert hall has been erected. This is utilized by the patients as a music and recreation room during the day, while in the evenings it is often the scene of high-class concerts and musicales arranged by patriotic and kind-hearted artists and artistes, the majority of whom have wide reputations as entertainers.

All visitors express the greatest admiration for the manner in which the Canadians have transformed the place into a veritable Garden of Eden. Lawns have been laid out, underbrush cleared away in the woods, beautiful old winding walks among the trees have been regraded and new paths run through; trees and shrubs have been trimmed, ornamental flower beds of quaint design planted, until now the surroundings present a most brilliant spectacle of horticultural grandeur, through which, placidly wending its course, is a quiet little stream that stumbles over the precipice beneath overhanging branches at the edge of the large lawn in front of the manor. Among the trees further down the stream the waters deepen perceptibly and form a pool which is at once a delight and diversion to all who enjoy a cool, refreshing plunge to the accompaniment of an ever-present orchestra of birds concealed among the leafy boughs above.

Then, too, there is the large vegetable garden and orchard with an abundance of growing vegetables and fruits of all kinds, large and small, sufficient for the needs of the hospital for many days to come.

The Canadian Red Cross Society is to be congratulated that its efforts to provide a suitable home of rest for conval-

escing Canadian soldiers are meeting with the success already attained at the King's Canadian Red Cross Convalescent Hospital at Bushey Park. This is in no small measure due to the efficiency of Colonel Hodgetts, commissioner of the society at 14 Cockspur Street, London, England. Colonel Hodgetts possesses the useful faculty of obtaining the greatest possible results for the least expenditure of money.

The commanding officer of the institution is Lient.-Col. Casgrain, who organized No. 3 Canadian Stationary Hospital in London, Ont., and went over in command of that unit to Shorncliffe, England, where it was largely due to his influence that Canadian medical men were first allowed to perform operations and attend the sick in the Military Hospital there. Col. Casgrain's unit, although organized for duty in France, volunteered for service at the Dardanelles, was accepted, and proceeded to the Island of Lemnos. While there the rigors of the tropical climate claimed Col. Casgrain for a victim, with the result that for more than two months his recovery was in doubt in a British hospital in Alexandria, Egypt. However, the Colonel is now busy demonstrating his administrative ability at the Bushey Park institution.

To the King's Canadian Red Cross Convalescent Hospital there come for rest and recuperation soldiers who were enlisted in all parts of Canada; men who fell wounded at Ypres, Givenchy, Festubert, Loos and St. Eloi, and men who passed unscathed through the horrors of those fields of carnage.

CANADIAN RED CROSS HOSPITAL OPENED AT BUXTON, ENGLAND

THE formal opening of the Canadian Red Cross Hospital at Buxton took place on August 13th in the presence of Sir Sam Hughes, of Ottawa. The Duke and Duchess of Devonshire, who are expected very shortly in Canada to occupy Rideau Hall, formally opened the institution. The Duchess had just completed a tour of the hospitals in Derbyshire.

Items

THE plans have been prepared for the new Fraser Building to be added to the Victoria Public Hospital at Fredericton, N.B.

The annual meeting of the Board of Directors of the King's Daughters' Hospital at Duncan, B.C., was held on May 24th.

The Cottage Hospital at Beverly, Alta., was opened on May 10th. It is one of the first hospitals to be opened in this country to be maintained by a municipality.

The following have been appointed House Surgeons at the Victoria Hospital, London: Drs. Stanley Murray, A. McKay, D. D. Ferguson, L. M. Jones and Renwick.

Dr. Hugh McKay, who has been the doctor at the Ontario Reformatory, Guelph, for some time, has been transferred to the staff of the Convalescent Hospital for returned soldiers at Cobourg, and left on July 21st to assume his new duties.

The 33rd annual report of the Prince Edward Island Hospital was published a few weeks ago. The hospital closed this year with a deficit of \$163.98, the deficit of the previous year being \$263.00. The number of patients who received treatment during the past year was 562, as compared with 417 during the previous year. Prince Edward Island Hospital now has accommodation for about sixty patients.

The annual report of the Alexandra Hospital, Montreal, shows that during the year 1915 903 cases were treated, including 417 of diphtheria, 292 of scarlatina, 183 of measles, 6 of erysipelas, and 3 of cerebro-spinal meningitis. The cost of maintenance amounted to \$2.20 a day per patient. As we already announced, the Nurses' Home was opened about a year and a half ago, and this has improved conditions at the hospital very materially.

The recent amendment to the Hospital Act in British Columbia now throws the onus of responsibility for hospital expenses incurred by its residents upon the municipality. Up till recently the municipality was only responsible for indigent patients, but as it is extremely difficult to prove that a patient is indigent, the hospitals have frequently been unable to collect the fees from either the patient or the municipality. Under the new arrangement, if the bill is not paid by the patient, the municipality will pay the hospital, and will then do its best to collect the amount from the patient.

A Hospital for Mentally Disabled Soldiers Opened at Cobourg

AT the request of the Dominion Hospitals Commission, the Ontario Government has donated the old Victoria College Building at Cobourg for the care of mentally disabled soldiers. Two expert alienists have been appointed to carry out the treatment, and up-to-date electrical and other appliances have been placed at their command. The new hospital was opened two weeks or so ago with eight inmates, and it is expected that others will at once be taken from the various institutions where they have been temporarily accommodated. In future all soldiers suffering from mental breakdown or disability will be sent to the Cobourg institution, where attractive surroundings combined with expert treatment may, it is hoped, remove the disability.

Another Hospital Opened for Canadian Officers

THE Perkins-Bulls Hospital for Canadian officers at Putney Windows, which overlooks the famous Heath, was opened on July 19th by the Lord Mayor, Sir Charles Wakefield, himself intimately acquainted with Canada. He spoke of the associations of the new hospital. William Pitt died in the adjoining house; Oliver Cromwell lived close by; Dick Turpin and Jack Shepherd knew every inch of the district.

Surgeon-General Jones read a letter of appreciation from the first five officers to occupy the hospital—Capt. McDiarmid, Vancouver; Capt. Eyres, Toronto; Capt. Bull, Winnipeg; Lieut. Clark, Calgary; and Lieut. Morrison, Halifax.

Sir Thomas MacKenzie, of New Zealand; Sheriff Touche and Sir Richard McBride, also spoke. Miss Fitzpatrick, of Hamilton, is Matron, and John T. Ryan, Secretary.

Book Reviews

A Text-Book of Physiological Chemistry. By O. HAMMARSTEN, Emeritus Professor of Medical and Physiological Chemistry, University of Upsala. Authorized translation for the 8th German edition, by JOHN A. MANDEL, of the University of New York. New York: John Wiley & Sons, Inc. London: Chapman & Hall, Ltd. 1915.

The revision of this edition was made with the assistance of Professor Hedin, of the University of Upsala, and was brought up to 1913.

Although the work has been enlarged, the number of chapters has been cut from eighteen to seventeen by combining Chapters I and II.

This translation is the seventh American edition and is very well done.

This book is probably the best there is in the English language, both as a reference book and working manual. Methods and tests generally are described in detail, and in such manner that the man in the laboratory can follow directions and get results.

The book contains many references to original articles; also index of authors and a very complete general index.

A Text-Book of Physiological Chemistry in Thirty Lectures. By E. ABDERHALDEN, Professor of Physiology of the Physiological Veterinary High School, Berlin. Translated by WILLIAM T. HALL and GEORGE DEFREN. New York: John Wiley & Sons, Inc. London: Chapman & Hall, Ltd. 1914.

This book is a compilation of thirty lectures and is therefore a book of reference rather than a working manual.

As stated in the author's preface, the aim has been to consider only subjects of general interest and importance, and which have been proved, omitting isolated facts and such as have not been definitely established.

Although printed in 1914 the translators' preface is dated 1908.

The subject-matter includes the topics ordinarily considered under this heading. A few tests and methods are given, but in a general way rather than in detail.

The book is well written and the translation is well done and forms smooth reading. The translators have used the systematized form of spelling recommended and adopted by the chemical societies of this country and England.

Industrial Welfare Number of the Modern Hospital.

The August number of *The Modern Hospital*, St. Louis and Chicago, is devoted to a symposium on welfare work among the industrial corporations of the country. There are editorials by those competent to write on this important subject, a great number of papers written by welfare directors in some of the most important industrial corporations, and an immense amount of statistics and figures and facts showing the huge volume of work that the corporations are doing to protect their employees against sickness, accidents and discontent. The journal contains many illustrations of first aid stations, emergency hospitals and welfare departments of industrial plants, and many facts that should be of great help to those interested. Among the topics discussed are those of first aid, industrial nursing, lunches and diets for industrial employees, safety devices in factories and athletic and social clubs for employees. The editors frankly state that they have been unable to obtain figures as to cost of welfare work in the industries, but a number of writers attempt to make deductions and draw conclusions from their experiences of the past few years.

The Modern Hospital divides welfare work into three phases:

1. To make employees healthy, comfortable and happy, in order that they may achieve the highest efficiency in their work.

2. To help employees prepare for the day when they are prevented from being bread winners, so that dependents on them may be provided for in cases of sickness or disability.

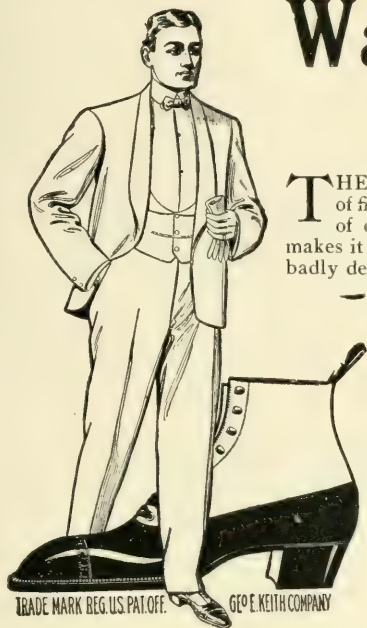
3. To provide entertainment, recreation and interesting groupings, in order that the employees of the corporation may have mutual interests which will enhance their loyalty and team work.

Some able writers have discussed the various features of welfare work for the different branches of industry, as, for instance, Dr. Thomas Darlington, former Health Commissioner of New York and medical director of the American Iron and Steel Institute, discusses the present scope of welfare work in the iron and steel industries. Dr. Samuel Lambert writes on provision for medical care under health insurance, and Dr. S. S. Goldwater, formerly Health Commissioner of New York, has an editorial on the conservation of health of industrial workers. Welfare work in the public utility corporations is discussed by Mr. H. H. Vreeland, general manager of the Interborough Rapid Transit Company, New York. Mr. James Prentiss Duncan discusses welfare work in the telephone and telegraph corporations. Mr. H. G. Kobick, manager of the employment department of the Commonwealth Edison Company, discusses welfare work in the electric lighting corporations. Mr. S. F. Moore discusses welfare work among the gas corporations. There are stories of welfare work in such department stores as Wanamaker, Macy's, Marshall Field, and similar great concerns. Mr. G. A. Ranney, secretary, discusses welfare work of the International Harvester Company. Mrs. Anne Kendrick Walker discusses welfare work among the clothing and suit manufacturers. A representative of Armour & Co. writes on the subject of welfare work in Packingtown, Chicago. Besides many more of these special papers, there is an epitome of welfare work in hundreds of the corporations of the country.

Perhaps the best feature of the industrial number of *The Modern Hospital* is the attempt on the part of the editors to weed out those features of industrial welfare that they believe undesirable and to emphasize those that seem to best meet the present needs of the American public.

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An attractive booklet, "The Sanitary Home," will gladly be mailed on request, by addressing the manufacturers, Henry B. Platt, 42 Cliff St., N.Y.

The Ostermoor Mattress

HOSPITAL Superintendents who are anxious to instal high-class bedding in their Institutions should, before doing so, communicate with the Alaska Feather and Down Co., Montreal. This firm recently equipped the New General Hospital, Montreal, as well as other large Institutions. The Ostermoor Mattress is resilient and ideal for Hospital use, as it will stand the hardest of wear without sagging. It sells at a very reasonable price and is composed of the best of material.

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UNDOUBTEDLY, the most important point to be considered in the selection of cocoa is purity. Many people, however, do not understand what is meant by the phrase "absolutely pure" as we apply it to Baker's Cocoa. It means that the cocoa has been prepared by a mechanical process; that it has not, during any stage of that process, been touched by chemicals; that only so much of the cocoa butter is removed as is necessary to make the cocoa more easily digestible and keep it in the form of powder; that nothing has been added to it; that it is all cocoa, nothing but cocoa, and *that* cocoa of high grade. It does not contain any added mineral matter.

Opposed to the cocoas made by the mechanical process are those prepared by the chemical or so-called "Dutch" process.

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Directions:—Always heat in the original container by placing in hot water. Needless exposure to the air, impairs its osmotic properties—on which its therapeutic action largely depends.



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Look at the labels on the packages of these cocoas. They bear the inscription "Contain per cent. of added mineral matter." Such cocoas are impure; they are adulterated by the addition of potash deposited during the process of manufacture; and the addition of potash even in small quantities offers a serious menace to digestion.

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Ziratal a New Antiseptic

A NEW germicide and antiseptic has recently been brought under the notice of the Profession in Canada under the name of Ziratal. It belongs to the Naphthalene series and is almost free from odor. Two teaspoonfuls to one quart of water can be used most effectively in washing out incised wounds. It not only is germicidal in action, but will arrest minor hemorrhage. For general disinfecting, as well as for laundry purposes, two teaspoonfuls to one quart of water will be the correct strength. The same strength should be used for washing out the bath tub, basin, toilet and for scrubbing floors and walls after contagious disease. For vaginal douche use one teaspoonful to the quart. Ziratal is quite pleasant to use and physicians will be pleased with the results.

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In these days when there is considerable trouble in reference to "help" in large Institutions, any effective labor saving device is more than welcome. One such device, which will make laundry work in a Hospital easy, is

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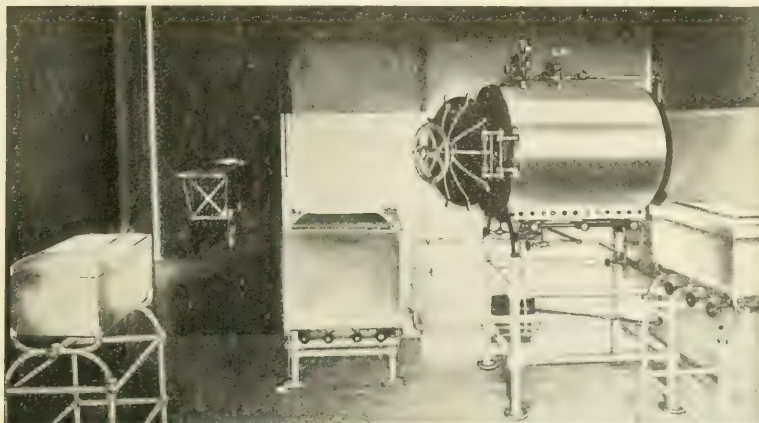
The Vortex System

INSTITUTIONS should look into the merits of the Vortex Individual Sanitary Service. This is essentially an advance along the lines of sanitary science and is ideal for use in hospitals, sanatoria, asylums—in fact, all public places. The idea is the adoption of the individual drinking cup, which each person uses and at once dispenses with the cup by throwing it away, thus avoiding contagion. The Vortex Service consists of heavily plated cup holders and rice paper cups, the latter made water-tight by a patented process. The cups are kept in silver-plated containers and are removed without even the hands touching them. The moment the cup is used it is discarded. With this system no time is lost in washing dishes and no expense of renewing broken glasses. The cups can of course be used not only for drinking hot and cold fluids, but also for serving ice-cream, fruit, etc. The Vortex System is not only sanitary, meeting every requirement of sanitary laws, but is quite economical. Could anything be more suitable for the average hospital, particularly in private patients' buildings? Full particulars can be obtained from the Canadian Wm. A. Rogers, Limited, 570 King St. West, Toronto.

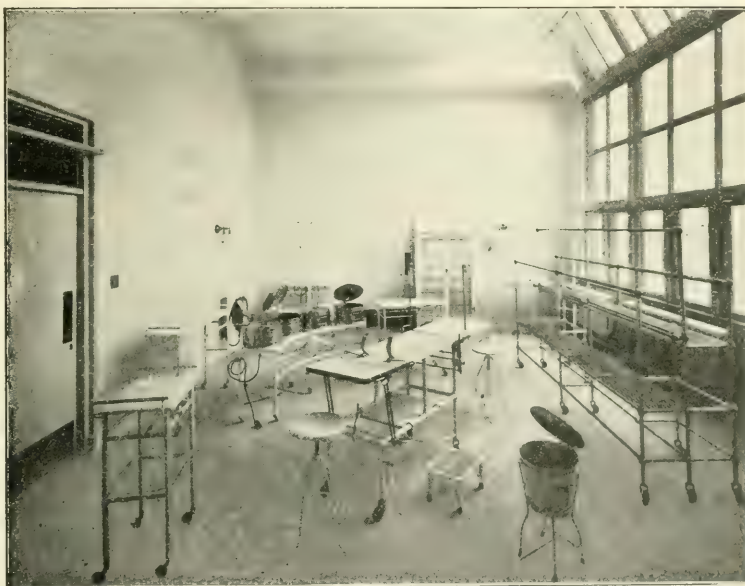
The Rigo Eye Pipette

READERS of this journal will note on another page of this issue the advertisement of the Rigo Eye Pipette, as manufactured by the Richards Glass Co., Limited, Toronto. Oculists are aware that sometimes injury is done to the eye through the use by the patient himself of an ordinary medicine dropper, as sold by drug stores. Frequently the edge of the medicine dropper is rough, setting up trouble in the eye as a result. The Rigo Eye Pipette, however, is made from heavy glass tubing, free from all defects, and is fitted with the best quality of rubber nipple. It is now prescribed by many of the leading oculists, both in Toronto and Montreal. The shape and style was first suggested by Dr. Gilbert Royce, who not only adopted the Rigo Eye Pipette for eye work, but also for introducing liquids in the post-nasal passage and for work on children's ears. The Rigo Eye Pipette can be procured at any important drug store or direct from the manufacturers at 265 Adelaide Street West, Toronto.

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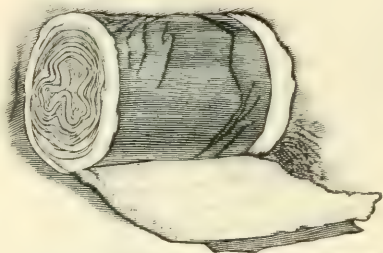
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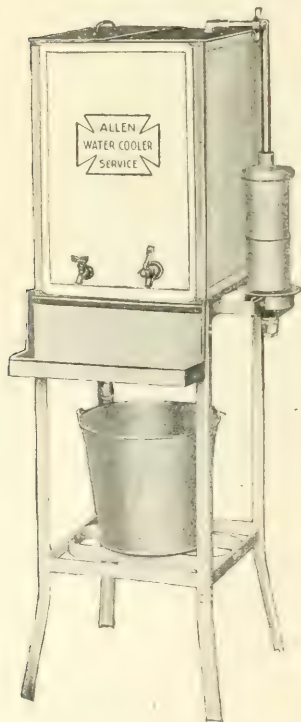
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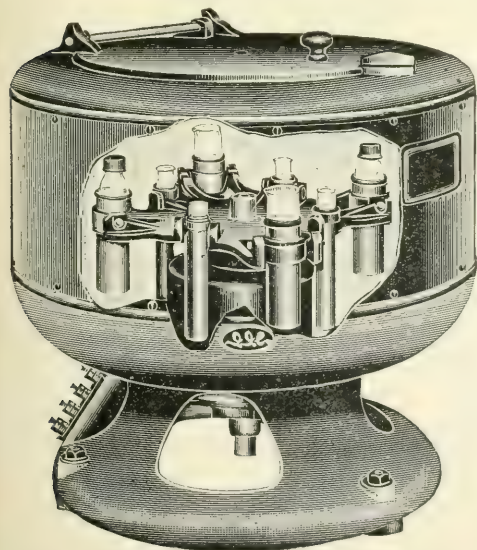
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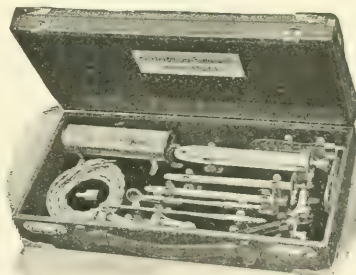
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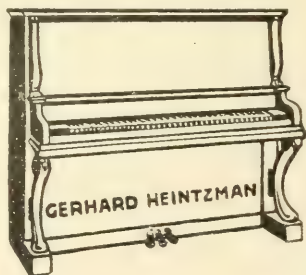
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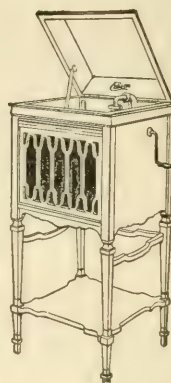
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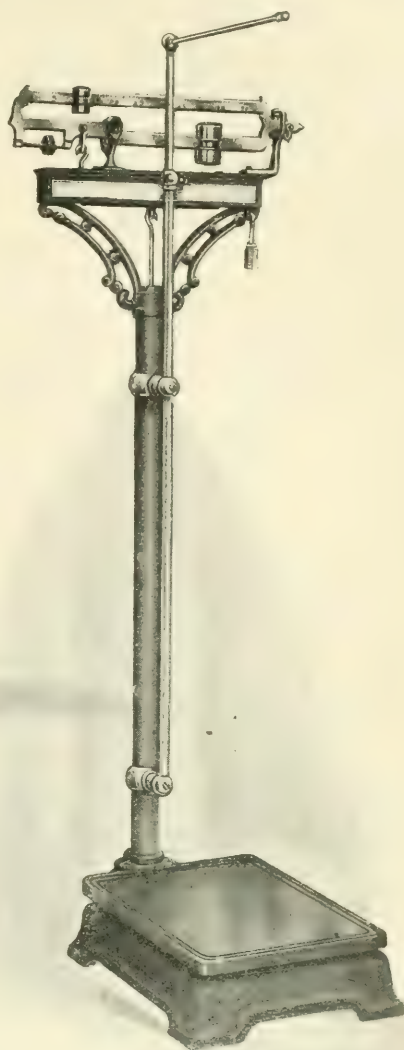
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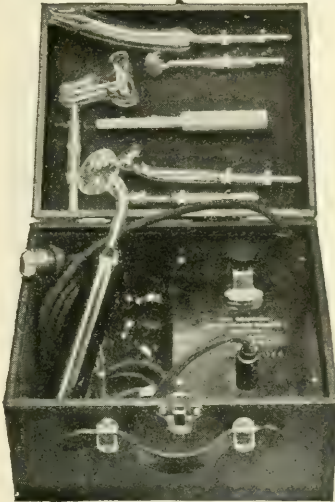
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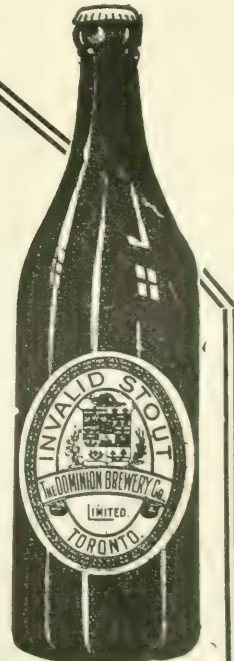
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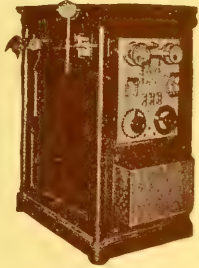
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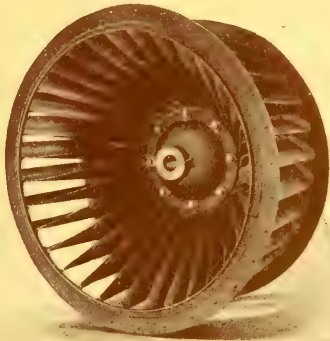
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Toronto, October, 1916

No. 4

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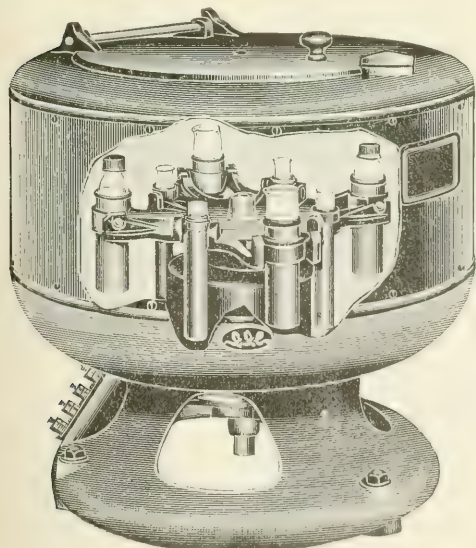
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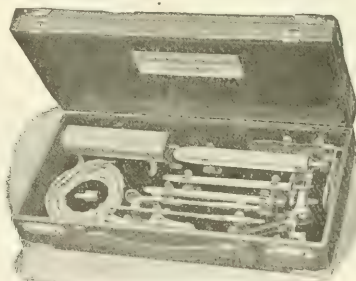
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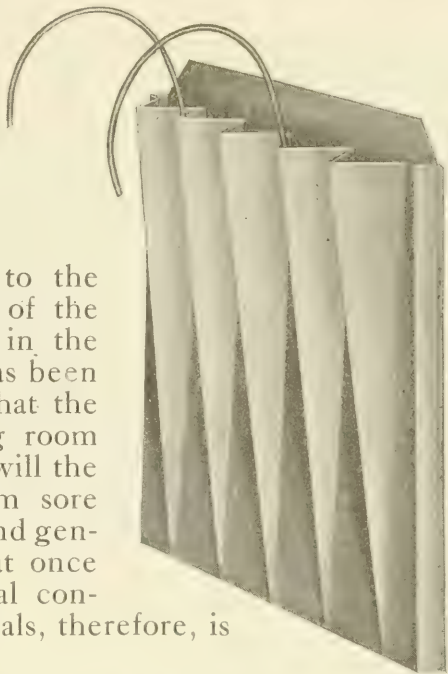
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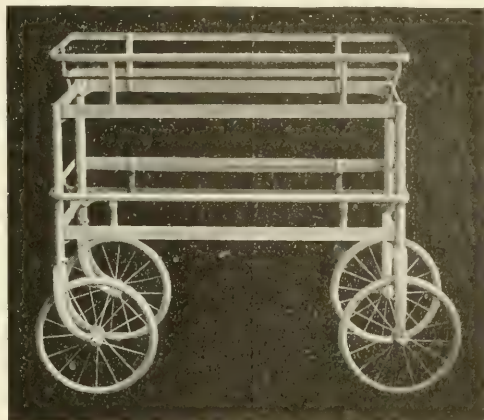
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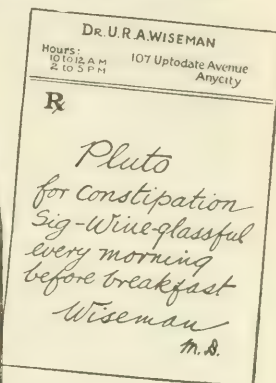
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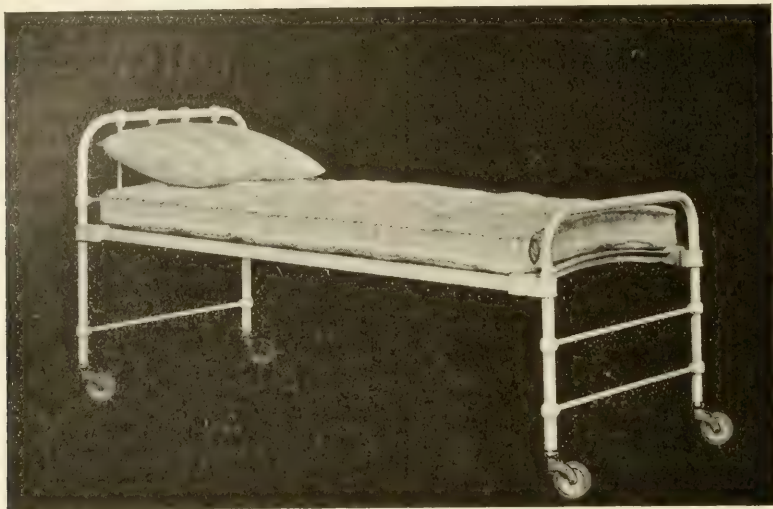
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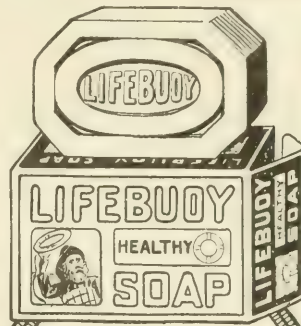


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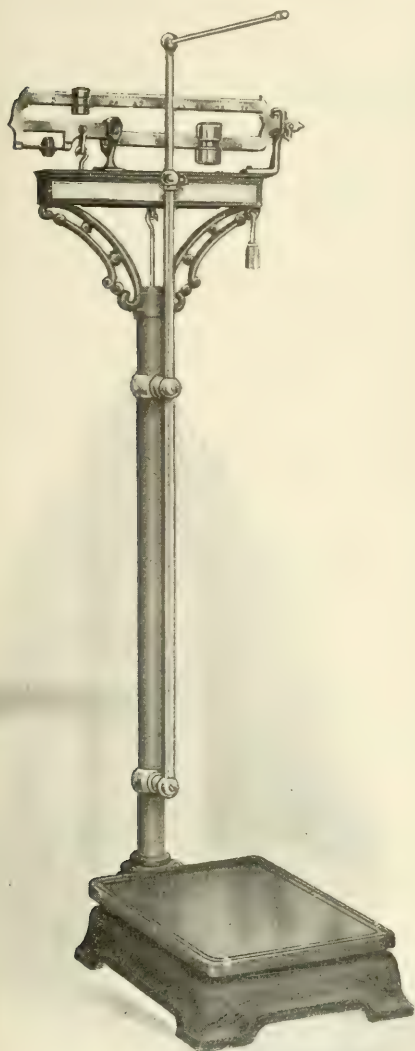
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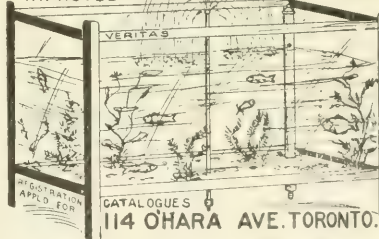
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Voi. X.

TORONTO, OCTOBER, 1916

No. 4

Editorials

RESUSCITATION APPARATUS

DR. YANDELL HENDERSON, Professor of Physiology in Yale University School of Medicine, has made a pronouncement on various mechanical devices for

resuscitating those who have been overcome by submergence in water, suffocation by smoke, stunned by electric shocks, overdosed with chloroform, and the like, where respiration has stopped, providing the heart has not come to a standstill.

Hospital superintendents who have of late and are at present being called upon by agents selling pulmotors, lungmotors, vivators, bellows, and other resuscitation apparatus, will do well to read what Dr. Henderson says about them in a recent number of the *Journal of the American Medical Hospital Association*.

In describing the action of the pulmotor, Dr. Henderson points out, that the purpose served by the compressed oxygen is not, as many suppose, to enrich the blood with that gas, but to supply the motive power which works the apparatus. He further shows that the valve which alternately provides for the blowing of the air to the face mask and then sucking it out when reversing is made to do so by means of a considerable positive and negative pressure that come just at those points in respiration at which they are most unnatural. Besides, if there be an obstruction to the flow of air, the positive and negative pressures needed to reverse the apparatus induce the suction and injection phases so rapidly that the patient's lungs are not properly distended and deflated. The injector is also liable to get out of order.

The automatic working of the apparatus has overimpressed the buying public; and many useless machines are now lying as junk around hospitals, firehalls, and factories.

The essayist writes more favorably of the lungmotor, which is really a combination of two such pumps as are used to inflate automobile tires.

The advisability of withdrawing air from the lungs is questionable.

But when all is said and done, too much reliance should not be placed on any of these devices. The old-fashioned methods of artificial respiration—the Sylvester and the Schafer—must still be taught and used; for one can not always wait until some apparatus is brought. The earlier efforts at resuscitation are commenced the better. If the apparatus has to be brought from a distance it generally arrives too late. A delay of five minutes, if no other means are used, is fatal.

Dr. Henderson says that harm may be done by exerting too great a positive pressure in using some of these apparatus. To lessen this danger, he suggests that in the apparatus of the pump type there should be a blow-off valve or equivalent device set to open under a water column pressure of 10 inches; and when, as in the lungmotor, there is also a suction pump, there should be an inlet valve set to open under a pressure of 6 inches.

The Resuscitation Committee, of which the essayist is a member, found that in a conscious, normal, not apneic, subject, his own respiratory centre, rather than the exertions of the operator, determines the amount of pulmonary ventilation afforded by the prone pressure method. Between the applications of pressure, the subject's respiratory muscles draw in what he needs—no more and no less. Besides, the amount of air which can be drawn in and

forced out by the manipulation of the arms and the squeezing of the chest and abdomen, gradually decreases as the body muscles lose their tonus. When the body becomes flaccid only a negligible amount of air passes in and out as a result of the pressure and relaxation.

AND THEN WHAT?

THE indefatigable Rockefeller Institute has undertaken to make an exhaustive survey of the City of Chicago with the view of ascertaining how much of the crime within its boundaries is due to sub-normal mental conditions, or, in other words, to obtain the statistical relationship between the mental condition of Chicago citizens and their crimes.

It appears to be a tolerably large undertaking, but the Institute is never troubled by the size of its contracts. It worries through them somehow, and after the expenditure of much money and labor sends another of its many startling volumes of facts and conclusions out into a scientific world already burdened with previous volumes of information it has not yet been able to digest or live up to.

Nevertheless, it is good to have a Flexner and a Rockefeller Institute, perhaps on the same homely supposition why it is good for the dog to have fleas. It keeps the conscientious section of the people alert and watchful and properly uncomfortable over evils that should not exist, yet that there is no clear and instant way to exterminate.

This investigation of sub-normality in Chicago now is quite a needful and desirable thing, at least so every other American city will agree. Chicago was doubtless selected because of its prominence in both these attributes of sub-normality and crime. To discover what proportion of Chicago minds are mischievously sub-normal and to decide what is going to be done with them when they are located will be a pursuit of great magnitude, and the published results will doubtless make more fascinating reading than any previous volume of the Institute records.

So large a staff will be necessary to carry on and complete this survey, however, that there is a possibility of a sub-normal mind or two slipping in among the investigators. And then what?

Original Contributions

ANTI-TYPHOID INOCULATION IN SOLDIERS

BY GEORGE D. PORTER, M.D., CAPTAIN A.M.C.

THE following is a brief report on the early results of 126,600 inoculations rather than a paper on the general subject of inoculation. It might be well to recall, however, that the excellent results which have followed inoculation in the British forces in India and elsewhere, and also in the United States army, have been largely responsible for its almost universal use in the armies of the world to-day. While sanitary measures in general have never been so closely observed as at the present time, yet the wonderful freedom of the troops from typhoid may be largely attributed to inoculation.

In Major Lelean's book on "Sanitation in War," he estimates that there are five and a half times as many cases of typhoid amongst the soldiers who are not inoculated, and that there are ten and a half times as many deaths amongst those unprotected by inoculation as there are amongst those who have been inoculated.

Another report states that from August, 1914, to November 10th, 1915, 1,365 cases of typhoid were reported from the front (1,150 verified by laboratory diagnosis). In 579 cases amongst the inoculated there were 35 deaths, while in 571 cases amongst those unprotected by inoculation there were 115 deaths. Owing to our lack of information regarding the number of inoculated soldiers who contracted typhoid, and those not inoculated who contracted the disease, it is impossible to compare the results, but these figures do show that the mortality is less than a third amongst those inoculated. Another list of figures taken from one of the British medical journals shows that in 1,347 cases of typhoid 891 had not been inoculated, while 225

had been. Of the 891 cases uninoculated there were 155 deaths, making 17.4 per cent. Of the 256 cases inoculated there were only 8 deaths, making 3.1 per cent. The mortality amongst those inoculated only once was greater than amongst those inoculated twice, and the mortality amongst those inoculated twice was more than amongst those inoculated three times.

In reply to a letter for further information, however, I have received a letter from the office of the Director of Medical Services of the Canadian Contingents in London, stating that "although the figures are such that they ought materially to help universal inoculation, the War Office refuses to allow any statistics regarding medical work to be published."

The technique used at the Laboratory in District Number 2 is to paint a small area beneath the clavicle with tincture iodine, and, after boiling the needles, syringes and plungers, inject subcutaneously one c.c. of the anti-typhoid vaccine, which equals a dose of 250,000,000 dead bacteria. The second dose of the same strength is given from four to ten days later, and the third dose of double the strength is given from four to ten days after that, making in all 1,000,000,000 dead bacteria. It is important to have the bottles containing the vaccine well shaken before using, also to have the rubber stoppers painted with iodine before inserting the needles through them for withdrawing the fluid. Our vaccine is prepared at the Provincial Laboratory, and must be kept in a cool place when not in use.

The redness and tenderness surrounding the site of inoculation which sometimes supervenes begins to subside in a few hours. As the constitutional reaction comes on about six hours after the inoculation, consisting of malaise, headache, a slight rise in temperature, and, in some cases, a tendency to faintness, light duties are advised for the men for 24 hours. When symptoms are severe enough the men are admitted to hospital under the head of "Inoculation Fever." The usual time spent there has been from one to three days, with an occasional illness lasting five days or a week.

We have inoculated in District Number 2 between January 1st, 1915, and May 1st, 1916, 42,200 men three times each,

making in all 126,600 inoculations. We have had no deaths from these, and, while there have been a number of somewhat severe reactions, there have been admitted to hospital for this cause only 107 cases—less than one-quarter of the men inoculated, or about one admission in every twelve hundred inoculations. (Over one-half of these admissions were during the summer months.)

We are now giving the combination of para-typhoid vaccines, and, while only a few hundred men have been inoculated with them thus far, the early results are just as satisfactory as with the typhoid vaccine alone.

PREPARATION OF A PATIENT FOR AN ANESTHETIC

R. J. MACMILLAN, M.D., TORONTO.

1. AS TO REST—All patients, where it can be arranged, should rest both physically and mentally, better in bed, for at least twenty-four hours previous to anesthetic.

2. AS TO NOURISHMENT—The diet should be regulated for at least two days previous to anesthetic.

The patient should receive abundance of nourishing, easily digested food. Food that leaves little residue. From the eighth hour preceding the anesthetic and up to three hours before same, light fluids should be given. The patient should be encouraged to drink water up to one hour before the anesthetic.

3. AS TO DRUGS—(a) Hypnotics for nervousness and sleeplessness the night preceding anesthetic.

All hypnotics tend to increase post-operative nausea and vomiting. Prional, sulphoral and veronal are the worst; chloral hydrate, paraldehyde and somnos are the best.

(b) As to use of morphia.—Morphia should always be given in very nervous cases, unless there are strong contraindications, and in all cases of Graves' disease. Best given forty-five minutes before, combined with atropine. Dose for an adult, morphia gr. 1-4 1-6, atropine gr. 1-150.

(c) Atropine. Atropine should be given in all cases. It lessens bronchial secretions. It lessens the escape of the heat of the body, thus lessening shock.

4. AS TO PURGATIVES—The best preparatory purgative is calomel given two nights previous to anesthetic, followed in the morning by a saline.

No laxative the night before. On the morning, two hours before anesthetic, an enema should be given. In operations on the lower bowel, more enemata will be necessary.

The usual custom of giving a purgative the night before, followed in the morning by an enema, disturbs the patient's rest, and leaves him in a condition far from the best to stand an anesthetic and operation.

It almost inevitably results in more or less severe post-anesthetic nausea and vomiting.

In cases where you only have your patient one day previous to operation, castor oil is better than calomel; it is less apt to be followed by vomiting. I am certain if the above lines as to diet and purgatives were followed, post-anesthetic nausea and vomiting would be very rare.

AFTER TREATMENT.

1. Post-anesthetic gastric lavage. I am certain that routine lavage does more harm than good in the majority of cases. Lavage requires that the patient be deeply anesthetized, and as in a great number of operations very light anesthesia is all that is required, it would be harmful to deeply anesthetize the patient for the purpose of lavage; then lavage entails some considerable shock, and in patients already suffering greatly from shock it might prove to be the last straw.

In the following cases lavage is indicated:

(a) In all operations where the stomach is handled, and in operations on the gall bladder. In these operations blood

or bile or both are forced into the stomach, and are better removed.

(b) In all cases while during the period of anesthesia the patient vomits or endeavors to vomit. In these cases during the act of trying to vomit, air is sucked into the stomach, and the passing of the stomach tube permits the gas to escape.

(c) In all cases where the stomach is distended with gas. These cases will usually require to be watched for distension later, and will be better off having the tube passed again.

The presence of gas in the stomach is more serious than fluids.

Many solutions are used for lavage. Normal saline, soda bicarbonate solution, lime water, weak solutions of hydrochloric acid, and plain warm water. The soda bicarbonate seems to answer best; it appears to wash the stomach better. It removes any mucus secretions better than others.

Some advise, after lavage, leaving in the stomach certain solutions, as $\text{3 i} - \text{3 ii}$ of soda bicarbonate in $\text{3 ii} - \text{3 iii}$ of warm water, or $\text{3 ii} - \text{3 iv}$ milk of magnesia. My experience is that it is a waste of material.

As to fluids and nourishment, post-anesthetic, as soon as the patient is able to swallow, they should be permitted, and if necessary encouraged, to drink water, given in small quantities, frequently. The temperature may vary as to the liking of patient, but never should be ice cold. As soon as the patient can take water without nausea, tea and other light liquids may be slowly added.

Selected Articles

REGARDING DIETS FOR PATIENTS *

No patient is to receive nourishment at meal hours without orders. Feedings between meals are not to be given unless ordered. No alcohol may be used even for flavoring, except by orders. Tea and cocoa are included in the liquids of any diet. Coffee requires a special order. No medical patients are to receive lobster, crab meat, raw oyster, raw clams, or cabbage.

Nurses serving trays must bear in mind the importance of preparing patients for approaching meal by announcement and by freshening bed, washing patient's face, and such methods of arousing the psychical stimulus for flow of gastric juice.

The following titles are in use:

Full diet.—Any available foods,—liquid, soft and solid, raw and cooked; 3 times a day.

Light diet.—Same as *full diet*, except no salads, no raw fruits, except oranges, no raw vegetables, and *limited amount*, small helpings, 3 times a day.

Soft diet.—Any liquid; eggs—soft boiled, soft poached, soft scrambled, and raw; toast—dry without crust; cereals—cooked; potatoes—mashed, creamed, baked; rice—steamed; gravies—meat and creamed, junket; jellies—without solid content; custards—without hard fruits; oranges, stewed fruits, 3 times a day.

Restricted soft diet.—Any liquid; eggs—soft boiled or poached or raw; toast—soft; cereals—cooked fine without chaff, as wheatena, or strained oatmeal; custard—plain; junket; jellies—plain; 3 times a day.

Liquid diet.—Any liquid, as milk, buttermilk, kephir, albumen plain, albumen flavored, grape juice, cocoa shake; soups—thin and thick from meat stock, thin and thick from vege-

*A dietary from one of our best known hospitals.

table stock (without solid content); tea, with sugar and cream; cocoa or chocolate; ice cream, without solid content; every 2 hours day, and at night if desired, in doses of oz. IV. or VI.

Intermediate nourishment.—Any liquid, oz. VI., with wafers if diet permits, at 10.30 a.m., 3.30 p.m., and in the evening.

Dubois Diet (Milk).

	6 a.m.		8 a.m.	10 a.m.	12 noon.	2 p.m.	4 p.m.	6 p.m.	8 p.m.
1st day	3 oz.		3	3	3	3	3	3	3
2nd day	4½ oz.		4½	4½	4½	4½	4½	4½	4½
3rd day	6 oz.		6	6	6	6	6	6	6
4th day	9 oz.		6	6	9	6	6	9	6
5th day	12 oz.		6	6	9	6	6	9	6
6th day	12 oz.		6	6	9	6	6	9	6
7th day	12 oz.		6	6	9	6	6	9	6
8th day				8			8		

On the 6th day, give bread, butter, and honey with the first 12 oz. of milk.

On the 7th day, give full noon and evening meals in addition to milk.

On the eighth day the following, full diet and milk at 10 a.m., 4 p.m., 8 p.m.

The nurses should not give any information to the patient about the diet schedule, amount, time, duration, or object. Simply reply that each feeding is ordered by the doctor.

Cardiac Diet.—Breakfast—Cereal with cream, 2 slices buttered toast, 1 soft egg, 1 slice bacon, 1 glass milk (200 cc.), 1 orange.

10 a.m. } 1 glass fluids and crackers, buttered toast or bread
4 p.m. } and butter, 2 slices.

Dinner.—Chicken, sweetbreads or fish; 1 vegetable (cooked); 2 slices bread or toast; any soup except from meat stock, 180 cc.

Supper.—1 egg, not fried; 2 slices bread or toast; simple dessert 1 glass any liquid.

Small amount of food.—*Exchange.*

GEOGRAPHY OF MEDICAL GREATNESS

In a recent number of *The Medical Times* appeared a humorous article on the above subject. Among other laughable things, it said:

When we think of Boston, medically, we think of Harvard and the Massachusetts General Hospital. They are the hubs around which medical Boston revolves. Relatively unlucky is the Boston physician who can own no affiliation with these corporations. He may be successful in a worldly sense, be a scholar and a gentleman, he may hold important institutional posts, but his sphere is an exoteric, relatively inglorious one. No great part does he play in sustaining the real palladia of Boston's medical greatness. He is a Philistine.

It is rather difficult for an outsider to understand the mystic, esoteric qualifications which a man must possess before he can aspire to a place within the sacred walls of these medical temples. The limitations of language do not permit one who is not a New Englander, much less a Bostonian, exactly to define the social and scientific sources of medical prestige in Boston.

Despite the foregoing conditions, the attainments of the scientific personnel of Boston's medical "trust" are of an astonishingly high order, as everybody knows—in the sense that there is nothing medical worth knowing that these gentlemen don't know. They know the scientific "patter" of medical science as they know the multiplication table, and they satisfy all possible requirements as regards Rabelaisian learning and impressive dignity.

One doesn't look much for anything erratic among such a personnel. One expects to find only conservatism. Occasionally, however, one encounters an individual among them who has a strangle hold on the trust as regards all the esoteric requirements for membership, and who yet exhibits phenomena strange indeed for a Bostonian of the sacred sort. Thus we see one of the near-great flying fitfully from social settlement work, applied to medicine, to psycho-therapy in conjunction with certain doctors of the church from blood researches

to denial of the trustworthiness of urinary findings as indicators of renal disease. Merely a clever, versatile man, opines the reader. Exactly, but think of the perturbing effect he must have on his staid confreres. To them it must seem like singing the Bab Ballads to the tunes of great hymns. This man, in such an environment, is like an aberrant embryonal cell. He would be a really inspiring figure in Chicago. He is as *outré* in Boston as a typical Bostonian would be in Oshkosh.

* * * * *

Members of the medical aristocracy of New York are the most fortunately situated as regards nearness to the concentrated wealth of the country. It is safe to say, too, that they are more than alive to their opportunities. He would be a unique thinker and observer who would deny that this "nearness" has had no reflex commercializing effect upon the profession.

The populace of New York probably receive more static wave thrills, at five dollars a thrill, more vibratory agitations, at five dollars per agitation, than any other neurasthenic community in the world. If you are a layman, you are irrigated for three months, subjected to vesicular massage for one month, passed along to the surgeon, who revises your table of contents, and end your days with a vacuum electrode against your prostate. Your spare time is passed visiting your relatives and friends in public hospitals and private sanatoria. People who claim to be healthy are detained at Bellevue until they promise to visit a physician. Females who do not bear upon their persons the heraldry of plastic geometry are very rare, and a child who needed no pharyngeal surgery would be entitled to a greasy effigy at the Eden Musée. Legion is the name of the neurasthenic, the sacred raven who bestows so much manna upon the Elijahs of Madison Avenue. Nowhere else are his symptoms so protean, though no neurologist has, as yet, reported a fear-of-money phobia.

* * * * *

It is customary not to approach Baltimore without removing the shoes, or in some way signifying one's deep reverence and

humility in the presence of greatness. Even the medical students at Johns Hopkins write learnedly and exhaustively upon themes to which Virchow himself could barely have done justice. You know that queer feeling that comes over you, reader, when you pick up a journal and read a title like the following: "The Psychology of Conversion in the Insane," by Mr. Philip Sydenham Lettsom, of the Senior Class, Medical School of Johns Hopkins University.

If the students are so wise, what shall we say of the residents? At the very beginning of their careers they have reached a development about equal to that of Benjamin Rush at the height of his career—no, not even excepting his wisdom. To them, "clinical medicine is a finished story," they know all that can be known about descriptive pathology, and the logical result is, they discover new diseases, devise new methods, write new books. Johns Hopkins has been launching this type of man for some years now, and it is a strange thing that medicine has not progressed faster at his hands.

As to the Olympian faculty which presides over the functions and destiny of the University, their wisdom passeth all understanding. It is said that they systematically withhold much of their knowledge for fear that its announcement would tend to paralyze effort in others—tend to intellectual pauperization, in other words—just as the man of colossal wealth has to exercise great care in his benefactions, in order that charity be not abused and the poor pauperized. Thus do they feed the medical chicks of the country within their capacity.

The professional body of Johns Hopkins is living, in point of fact, somewhere around seventy-five years ahead of actual scientific time. There is an apparently well-founded rumor that the members of this teaching body hold secret sessions at which the papers and discussions are pitched in a key which would strike any other medical men as transcendental, to say the least.

The faculty have been inclined to regard at least one professor as sensationally inclined, and have regarded as rather indiscreet deliverances his articles and addresses upon the subject to measurement of the capacity of the renal pelvis as a

routine office procedure, and upon the cure by means of radium of deep-seated and extensive cancer. In the faculty's judgment these are things that the general profession is not yet prepared to receive, and they do not consider that any purpose is served by such pronouncements other than the exploitation of the professor himself.

Great was Diana of the Ephesians, but greater is Minerva Medica of Baltimore!

THE ABUSE OF THE FREE DISPENSARY PRIVILEGE *

BY EDWIN B. MILLER, M.D.

THE trite saying that "Fools rush in where angels fear to tread" is probably true of the person who attempts to write a paper on the above subject and to read it before a body like the Philadelphia County Medical Society.

It is necessary in a discussion of this kind that the truth shall be told, regardless of the fact that some of the statements may seem like knocking an individual, a group of men, or an institution. So, in the words of Abraham Lincoln, "With malice towards none and with charity for all," I will proceed to a consideration of our subject, which, while a very old and much discussed one, is always new. The causes have always been the same, the methods of overcoming the condition well understood, and would be efficient to correct the evil; but what has been lacking? *Men of moral courage and stamina, who are willing to sink their individual opportunities for the good of the profession as a whole.*

I propose to point out to you that both the layman and the practitioner are responsible for the conditions which exist today in the dispensary service of the large hospitals of our city.

*Read before the Kensington Branch of the Philadelphia County Medical Society.

The most noble and notable example of Christian charity is the free dispensary, which, by the gratuitous service of the conscientious physician, is able to minister to the needs of suffering humanity.

These blessings are so common in this country that they are little appreciated, and their importance is not seen here, as it is in heathen lands, where the whole system of the civilization of the individual, the development of commerce and industry, and the upbuilding of nations, leading them out of darkness into light, freedom and usefulness, follow in the wake of the medical missionary.

In Korea the beginning of the present forward movement dates from the time when Dr. Allen, a medical missionary, ingratiated himself into the favor of the Emperor by curing his son of erysipelas, after all the native doctors had failed by their methods to give him relief.

Sir Robert Hart, ex-Director of Maritime Customs for China, is at the present time in England endeavoring to raise \$500,000 to endow a medical university in China; for all this service nothing is asked, medical men give their time, their talents, their money and even their lives for the cause of humanity.

All this is good and noble, but a thing which, at one stage of civilization, may be right and uplifting, becomes demoralizing and reprehensible at another. When these heathen countries take their places in the galaxy of nations and their sons and daughters become educated physicians, and their people become efficient by the development of trades and the various industries, they must be lifted to a higher plane than that of helpless mendicants.

We care for our children when they are helpless, but insist on their becoming self-supporting as they arrive at maturity; so the nation also fosters infant industries, but when they become trusts and can count their profits by the millions such protection should be removed.

In civilized lands it is the duty of the individual, the State and the nation to help the indigent; but it is little short of criminal to distribute the bounty to those who do not need it, thereby encouraging them to become dependents on the community and

thus depriving many worthy persons of their just requests for aid.

These conditions have reached such a stage here in Philadelphia that they menace the very existence of a body of men who have done more than any other in the work of saving humanity from the ravages of disease.

Thousands of persons who, by all the principles of justice and honor, should call on physicians to treat their ailments and pay for them, are being treated at the free dispensaries of our city. How much surgery do we get to-day even of a minor character? Why, frequently we find our best-paying patients are being treated in the hospitals gratis, because the impression seems to be abroad that it is only there that they can receive the proper attention.

I take it that the three principal causes for this state of affairs are:

1. The desire on the part of the patient to save money—the prevalent spirit of wanting something for nothing.
2. The desire to see the professor or the near-professor.
3. Because the patient is recommended to go to the dispensaries by their physicians.

1. *The desire of the patient to save money.*

I have known of large families who have not engaged a physician until their children are wage earners, and then they only do so because it is now cheaper to go to the doctor's office in the evening than to the dispensary. *Open the dispensaries from 7 to 9 p.m. and we will probably shut up shop and seek other and more remunerative fields.*

A child was brought to my office with a Colle's fracture. I treated the case and told them to bring her in the next day. They never came back, and when I went to hunt up my splint, I found that the patient was being treated at the hospital. The excuse offered was that they could not afford to pay, although the father had a steady job at \$18.00 a week.

Last week a man came to me who had been receiving x-ray treatment for carcinoma in a hospital dispensary for a period of nearly a year. He became dissatisfied and wanted me to

treat him. When I told him my price he demurred, saying he could not afford it. I reduced it. He said this was beyond his means. I made a still further concession, but he said he could not afford even this amount, so I advised him to continue treatment at the hospital, where he had already received service to the value of \$500.

I have learned since that he has a small store, an interest in a milk business and is the reputed owner of several houses. He wanted to save money, as he was losing some by being absent from his place of business several hours each day.

The public should be given to understand that to accept service to which they are not entitled is common robbery. The institutions that have special clinics: the eye, the nose, the throat, nervous diseases, etc., are the ones that are most patronized by this class of mendicants. Those who have worked in these clinics will bear me out when I say that probably one-half of all persons treated are able to pay. These same people will accept the hospital glasses from the optician for a dollar or two, and then order a pair for dress and pay \$7 or \$8 for them. I have seen a number of incidents like this and it is by this means that the optician is able to profit on the proposition. *Frequently patients attending special clinics will have two or three cards and will go from one clinic to another.*

2. *The desire to see the professor.*

This is probably due to the readiness with which the doctor in general practice calls in a consultant to tell him something he already knows, and introduces him as from such-and-such a hospital. The practice of calling in our neighboring brethren has been almost entirely abandoned.

This practice should be revived and a better understanding and more brotherly feeling would exist, for I take it that, *when the average intelligent physician does not know what ails a patient the professor is guessing, too.* Again, those of us who work in various clinics know that the assistants do all the work, and the chief only appears occasionally, and then only looks at the most interesting cases.

The chief of the clinic usually resists any effort to cut down

the size of the same. While working in the medical clinics of one of our prominent hospitals, a very well-dressed woman came in and asked to see the professor. The chief was not there, so I gave her a card and sent her to his office. At the next clinic he called me down, and informed me that his reputation at the institution depended on the size of the clinic, and to treat all comers regardless of their appearance.

3. Because they are recommended by their physicians to go to the dispensary.

This brings me to the most interesting part of the subject. It seems almost incredible that a physician should recommend a good patient, who is willing to pay, to go to the dispensary; yet such is the case, as I can prove, and these are, I believe, the causes:

1. Because the doctor has no knowledge of the conditions and has not instruments to treat the cases. This, to my mind, is a very poor excuse—he should have them.

2. He is afraid of, or jealous of, his neighbor, who has the knowledge and appliances, and the down-town specialist charges too much.

He may have good cause for this position, but when we get together and all try to act on the square this cause will disappear.

3. He is asleep and is not cognizant of his opportunities, or is too lazy to study, or too mean to buy books and instruments, I am satisfied that we—and I include myself among this number—allow thousands of dollars' worth of work that we can do to slip through our hands. This is due to careless methods of examination and observation and an utter neglect of the taking of records. We can do surgical work, eye work, ear, nose, throat work, stomach washing, treat hemorrhoids, use massage, hydrotherapy, electricity. *Why not?* The opticians are getting rich on the work sent them by physicians. A prominent optician soliciting my patronage showed me a list of physicians who sent him cases to be tested (mind you) and fitted with glasses, and the doctor who sent them received from \$1 to \$3 for each case. By doing this work himself he could hold

his patients, give them better service, because he should know more about it, and at the same time make more money with little or no increased cost to the patient. Let us get busy. In order to satisfy myself as to the position taken by the hospitals, I wrote to the superintendents of twenty-five institutions in Philadelphia and asked them the following questions: 1. Do you now, or have you at any time, tried to limit your service to those unable to pay? 2. *Do you charge for medicines or dressings?* I have received replies from twenty, and am pleased to say that some effort in this direction is being made. I have tabulated the replies, which are as follows: The hospitals who limit their service to those unable to pay are fourteen. The hospitals that make no special effort are six. Hospitals that make a definite charge for medicines are five out of twenty. Charge, but have no fixed sum, nine. Hospitals that make no charge for medicines are three out of twenty. Hospitals which give no medicine are two out of twenty. Hospital which makes no effort to limit its services and gives free medicine is one out of twenty.—*Exchange*.

THE PASSING OF DR. FRANK HAMMETT HOLT

DR. HOLT, aged 47, is dead after a brief illness. Deceased was Superintendent of Michael Reese Hospital for a year or so past. He went to Chicago from Boston, where he graduated in 1899. At the Boston City Hospital he served as an assistant administrator under Dr. Rowe for many years. Following Dr. Rowe's retirement and Dr. McCallum's transfer, Dr. Holt was looked upon by his outside friends as the logical appointee to the position in Boston. However, Municipal politics decided otherwise, and Dr. Holt was taken to Chicago, where he fully sustained the reputation he made in Boston as an efficient officer.

Dr. Holt became known to hospital people generally at the Boston meeting of the American Hospital Association, having had charge of the arrangements for the convention. His work in this connection was well done, and everyone appreciated his courteous attention and kindly assistance. Our representative on more than one occasion has been the recipient of Dr. Holt's generous hospitality, and the *Hospital World* joins his hosts of friends in extending to his family and relatives its sincere sympathy.

Canadian Hospitals

No. 4 GENERAL HOSPITAL (TORONTO)

THE following letter from a member of the staff of No. 4 General Hospital at Saloniki is most interesting, and gives some little idea of the work done by that splendid unit:

"No doubt you know all about the fact that we have left our old home on the other side of the city and have said good-bye to our tent hospital, for the time at least.

"Our move was effected in a very orderly manner. About a month before the move was made, three or four of us sat down and figured out just how it was to be done, and had practically arranged each load so that when the orders came for us to pack up we were quite prepared, and carried the thing through in such a way that we were able to immediately set up and equip each ward practically from one truck load. By this means there was no delay at the new site, and the handling of our equipment was reduced to a minimum.

"When we had occupied this new hatted hospital, we found it in anything but a fit state for us to carry on our hospital work. Since the buildings were available in a more or less incomplete state, but only five per cent. of the water supply had been installed, no sanitary or disinfectant arrangements for the patients or personnel. For the first week or ten days we had all our own men very busy trying to rush along various necessary details to enable us to accept patients at the earliest date, and we lent every assistance in our power to the Engineers' Department in an effort to hurry along the work of the hospital, but there were other conditions developing that would not wait for the leisurely progress of the Engineers' Department in completing the work here.

"About this time the extremely hot weather began to manifest its effect on the troops, and the medical staff officers became so pressed for accommodation that they asked us to open up to our fullest capacity and carry on the work as best we

could under the existing circumstances. This we did, and inside of the first twenty-four hours we accepted about 700 cases. It was a most trying experience, especially for my Quartermaster's Department, in attempting to handle this sudden inrush of cases, as we were particularly anxious to thoroughly clean all the men and disinfect their kits before admitting them to the new hospital wards. As no facilities were yet available for carrying on this work, it meant that we had the whole of the ground in the vicinity of the bathing establishment covered with the outfits of the men, and for a time we were almost discouraged over our unavailing efforts to cope with the disinfecting problem.

"Finally we succeeded in getting hold of two old thresh disinfectors at the ordnance. When we attempted to move these to our camp, a distance of some eight miles, both broke down on the way, and one of them had to be hauled in with big beams doing duty for wheels. However, this gave us something to go on with, and we gradually ate away at the tremendous accumulation of kits until we finally caught up.

"Recently the D.D.M.S. asked us to increase our capacity to 1,540 beds, and this was effected by placing 30 beds in each ward instead of the customary 24, and also taking over a group of buildings belonging to one of the adjacent hospital sites.

"When we first came to the hospital site we were very much bothered by the hosts of flies, and our first move toward solving this problem was that of cleaning up the camp area. Having accomplished this, we screened the windows and doors everywhere with mosquito netting, and then went after the pests with traps, swatters and poison of various kinds until, in a comparatively short time, we were able to notice that the numbers were markedly diminishing, and this has improved until, at the present time, we are very little bothered in that regard.

"Our hospital is really going to be a splendid institution when it is completed. We have 44 large wards, each 120 by 20 feet. These are subdivided at one end into three or four rooms for the carrying on of the work in each building. There is a bathroom, a room for washing up the patients' dishes,

with sink, running water, a sort of pantry with stove, and an administrative room for the use of the sister. The main ward itself is large, airy, bright, and has two large doors in each end and one on each side in the middle. Normally they are expected to house two patients, and when we are operating at our unusual capacity of 1,000 beds, this will be the number that we will place in each one."

OPENING OF THE NEW RECEPTION HOSPITAL, BROCKVILLE

THE new Reception Hospital in connection with the Eastern Hospital, Brockville, was opened on August 16th, 1916. This hospital, which is built of brick, three storeys high, is admirably situated about midway between the Prescott Road and the main building of the institution. Nature has supplied a beautiful setting for it, as it is placed in a grove of trees and has a splendid outlook on the St. Lawrence River. It is intended to accommodate sixty patients, thirty of each sex. Every comfort and convenience known to the science of mental healing has been carefully considered in the planning of this structure. In addition to four solariums, four large verandas have been provided where the patients will be treated with nature's own healers, fresh air and sunshine. These verandas have been provided with closed windows for winter, so that they can be used at all seasons of the year. Beds have been supplied with special rollers so that nurses can move even the weakest of patients onto the verandas without any disturbance.

The main floor of the hospital contains the doctor's office and dispensary, the head nurse's suite of rooms, the diet kitchens—which are fitted with every modern and labor-saving device—and the wards and special bathrooms for patients. The bathrooms and lavatories are all tiled and fitted up in the most modern manner.

On the second floor are the Resident Physician's apartments (the Assistant Superintendent, Dr. Geo. C. Kidd), patients'

wards and private rooms, attendants' quarters, also spray bath, bathrooms, etc.

The third floor is fitted up with nurses' quarters, storage rooms for patients' clothing, and the operating room, which has in connection with it a sterilizing, anesthetic, doctors' and nurses' rooms. All the fittings are of the most modern type, and it is one of the best operating rooms to be found east of Toronto.

The basement contains the boilers for heating water, electric motors for the operation of the elevator—which works automatically by the key method—also, the electric ventilating system which is very complete, changing the air in the whole building in a very short time by the means of fans, one placed in the basement and the other at the top of the building. The hospital is to be heated from the central heating plant.

An electric lift is provided for conveying food from the kitchens to the second floor, where food wagons are provided to transfer it when required to the pleasant dining rooms located on this floor.

A noticeable feature of this building is the homelike atmosphere that permeates into every nook and corner.

The grounds surrounding the hospital are being laid out in terraces and, in a short time, will be transformed into a bower of flowers and shrubbery.

The building is intended to be used entirely for the treatment and care of recoverable patients. Continuous baths with other hydrotherapeutic equipment and massage tables are being provided, so that nothing will be left undone which will give the patient an opportunity to make a recovery. The entire equipment of the building, with few exceptions, has been manufactured at the Ontario Reformatory, Guelph, Ont.

The opening of this building was made the opportunity to hold a special meeting of the Leeds and Grenville Medical Association and all the doctors in the Eastern Hospital District were invited to attend as guests of the Association and the Ontario Government. About fifty medical men responded to the invitation and sat down to a choice luncheon, provided by the hospital, at one o'clock.

After the inner man had been satisfied, the meeting adjourned to one of the spacious verandas, and at 2.30 the meeting was called to order by Dr. J. C. Mitchell, Medical Superintendent of the Eastern Hospital, who is also President of the Medical Association.

In a brief address, he spoke of the movements leading up to the erection of the building. He said the idea of this Reception Hospital was first conceived by Dr. J. M. Forster, who was Medical Superintendent of the Eastern Hospital for six months and who is now in the same capacity at the Hospital for the Insane in Toronto. Dr. Mitchell then gave a short history of the hospital and spoke of the great interest taken in it by the Honourable W. J. Hanna, Provincial Secretary, when the idea was first suggested to him. This gentleman came personally and selected the site for the building and, at the same time, made the purchase of the Hospital Farm which has proven so successful. He also referred to the work that is being done in the other Hospitals for the Insane in the Province, and of the special work it is intended shall be done in this hospital. He mentioned particularly that only those cases considered as curable would be admitted. He also gave a short sketch of the Leeds and Grenville Medical Association.

The Secretary of the Association, Dr. F. S. Vrooman, now Superintendent of the new Military Hospital in Cobourg, then read the minutes of the inaugural meeting of the Association and tendered his resignation on account of change in residence. The meeting elected Dr. M. F. D. Graham, Assistant Physician of the Eastern Hospital, as his successor.

Dr. T. F. Robertson, as Chairman of the Committee on Revision of the Tariff, then read the new tariff as applying to the counties of Leeds and Grenville. This was passed unanimously by the members of the Association.

S. A. Armstrong, Esq., Assistant Provincial Secretary, was then called upon and gave the following address:

"Perhaps you will appreciate my feelings appearing before you as the sole and only layman at this Conference, but it gives me great pleasure to be able to express to you, on behalf of the Government, its appreciation of your attendance here.

"It is the policy of the Government to encourage conferences of this character at the different institutions in the Province in order that the medical men may be given an opportunity to judge of the work that is being done in these institutions. This hospital, which is being opened to-day, is a splendid example of the policy of the Department with respect to the hospitalization of the public institutions in this Province. Public opinion seems to be that a patient sent to an hospital for the insane is sent in reality to a house of detention and not to a hospital for treatment. We have been endeavoring in the years past to correct this impression in order that no stigma may attach to a patient admitted to an institution. To this end, the Government no longer uses the term "Asylums," but our public institutions are known to-day as "Hospitals for the Insane," "Hospital for Feeble-Minded," and "Hospital for Epileptics," as the case may be. In addition to this, legislation has been passed which enables a patient to enter a hospital for the insane as a voluntary patient. The patient may make application of his own accord, or it may be made by his friends, instead of his being admitted on two medical certificates, in the usual way.

"Legislation has also been passed whereby municipalities having a certain population may have a Reception Hospital for the treatment of mental diseases. The cities of Toronto, Ottawa, and Hamilton, I believe, come under this class.

"The magistrate may commit to this hospital for observation, the medical practitioner may also make arrangements for the voluntary admission of a patient, or, his friends may make application for him. The patient is held there for a limited time and if his symptoms necessitate it, he is transferred to a hospital for the insane in the usual way. If not, he is discharged as "recovered" without having entered a hospital for the insane.

"We have one such hospital in the city of Toronto, and the city contributed to it by providing the building and equipment and paying \$7.00 per week for patients—the Province assumes the remainder of the burden, if any.

"The Reception Hospital which we have opened here to-

day is of a somewhat different character, as it is a hospital for the admission of acute cases which would otherwise be sent to a hospital for insane in the usual way. Chronic cases will not be received here—only acute cases who will profit by treatment. The most modern plans necessary for a hospital of this character have been adopted in its erection.

“Training schools for nurses have been established throughout the Province, and all nurses who enter the hospitals for the insane must take the training, which consists of a three years’ course, and examinations are conducted by an examining board appointed by the Provincial Secretary. Nurses who graduate from these training schools are equal in training, standing, etc., to those graduating from the general hospitals in the Province.

“In connection with the Military Hospital at Orpington, England, I might state that a psychopathic section has been opened and we have twenty of our graduate nurses there who were chosen from the public institutions of this Province. They have shown up well in comparison with nurses from other hospitals and I am sure they are reflecting credit upon the training schools and upon the Province.

“At Cobourg we have established a Military Hospital for the reception of cases suffering from mental and shock troubles. This hospital is unique in the fact that the electric baths, hot air cabinets and much of the other treatment equipment were manufactured in the Province of Ontario for the first time. We take some credit for this because of the fact that medical men, architects, hospital superintendents and others have always been of the opinion that it was necessary for them to go to the United States to get this equipment, but it has been satisfactorily shown that no better equipment is to be had than that at Cobourg. I expect that this hospital will reflect some credit on the Province. Ours was the only Province asked to contribute such a hospital, which goes to show that the hospitals for the insane in this Province are well organized.

“The President has requested me to speak of the new hospital for the insane at Whitby. In order that you have any idea of this hospital, it is necessary for you to see it, no words of mine can adequately describe it and the work we are doing there. It has been the aim of the Government, just as it was the aim of

the Government in the construction of the Reformatory at Guelph, to have the best on the Continent of America, or any other Continent, and in that, I think, we are succeeding.

"The President has also asked me to mention the cases that are being received in the Reception Hospital, Toronto. We have about fifty cases per month and discharge as cured approximately 50 per cent. The remaining 50 per cent. may, in time, be cured in a hospital for the insane, but the actual discharges as cured amount to about 50 per cent.

"I realize that you have a lot of business to transact, and will not take up your time further. It has afforded me very great pleasure to be here."

Dr. J. L. Chabot then gave a very comprehensive paper on the "Importance of More Attention to Surgical Cases." He emphasized the fact that physicians in diagnosing cases should lay greater emphasis on the family history of patients, including all forms of mental derangement. He spoke very strongly on making a careful and accurate diagnosis on each and every individual case, as many could be benefited by early surgical interference.

Drs. D. O. Alguire of Cornwall, Hon. R. F. Preston, M.P.P., of Carleton Place, D. Wallace of Kemptville; D. T. Smith, R. N. Patterson, A. S. McElroy and Major J. Fenton Argue, of Ottawa, discussed the paper very fully and in a most interesting manner and spoke in the highest terms of the points which had been brought out so clearly by the talented surgeon.

Sir James Grant, with his usual eloquence, gave an address on the benefits to be derived from the use of the neurotone in nervous cases. His address was listened to with the deepest interest, and everyone was surprised with the wonderful vigor displayed by the veteran doctor.

At the close of the meeting, the guests were conducted through the hospital and the various equipment and methods of treatment used in nervous and mental cases were exhibited.

Everyone went away expressing themselves delighted with the meeting and entertainment, and greatly pleased to have such a hospital placed in this district.

THE PRINCESS PATRICIA CANADIAN RED CROSS CONVALESCENT HOSPITAL

THE Canadian Red Cross Association are equipping a new hospital of one thousand beds at Ramsgate, England, at an estimated cost of one hundred thousand dollars. It is to be called the Princess Patricia Canadian Red Cross Convalescent Hospital, and the beds are to be subscribed for at the rate of fifty dollars each. It is intended that there will be a tablet at the head of each cot giving the name of the donor.

THE HOSPITALS COMMISSION REQUIRE FURTHER SANATORIA

THERE were, a few weeks ago, 331 returned Canadian soldiers under treatment for pulmonary disease in the various Sanatoria throughout Canada under the control of the Dominion Hospitals Commission. About 180 more soldiers returned recently to Canada who have contracted lung trouble while on active service, and before the war ends it is expected that the Commission will have to look after several hundred more such cases. In order to provide for the care of these men, the Hospitals Commission are very anxious to hear from patriotic citizens who will undertake to offer them the use of buildings suitable for this splendid work. Amongst the institutions already placed at the disposal of the Commission for this purpose are Deer Lodge, Winnipeg, Manitoba; Ogden Hotel, Calgary, Alta.; and the Haventide Inn, Ste. Agathe, Que. We trust that the need for further buildings will be supplied without delay.

Hospital Items

THE late Mrs. Martha A. Miller has left \$1,400,000 for the establishment of a hospital for the poor of St. Paul.

Robert Crozer, of Chester, Pa., has left \$100,000 for a hospital.

Mrs. T. H. Buhl has donated \$50,000 to Harper Hospital, Detroit.

Columbia University is in receipt of \$100,000 from Emil C. Bundy, to be used in cancer research.

The "Presbyterian," New York, has been left \$350,000 by Chas. Harkness.

John McDonald, of Monticello, Ia., has left \$100,000 to be used in constructing a hospital for the poor.

Edwin McClellan, of Cambridge, New York, will build a memorial hospital to his mother to cost \$150,000.

Mrs. Mary Osborne Graves has given \$25,000 for a hospital at Georgetown, Ky.

Nurses at the Alta Bate Sanitarium, Berkley, California, had \$200 stolen from them in the Nurses' Home by a sneak thief.

Two hundred Boston physicians are proposing to build a co-operative hospital at Stoughton. Members of the Association pay \$10 per year which will entitle them to hospital care.

A nurse at Fabrola Hospital, Oakland, California, burned a patient with a hot-water bag. The patient sued the hospital, but lost the suit because the nurse was a private nurse, brought in by the patient's physician.

Book Reviews

Physiological Economy in Nutrition, with Special Reference to the Minimal Proteid Requirement of the Healthy Man. An Experimental Study. By RUSSELL H. CHITTENDEN, Ph.D., LL.D., Sc.D., Professor of Physiological Chemistry in Yale University. New York: Frederick A. Stokes Company, 1913.

In opening his epoch-making volume, the author refers to the work of Voit on the subject of nutrition, which has for a good many years been considered as authoritative. Chittenden's experiments have resulted in a new standard of requisite proteid intake.

Experiments, covering months, were undertaken with a group of five university teachers, thirteen soldiers—both groups of varying ages—and of eight student athletes of Yale.

The work undertaken—that of measuring the intake in proteid, fats and carbohydrates and also of the constituents of the fecal and urinary excretions—was one that required great care and painstaking effort. The students of physiological chemistry will study with much interest the scores of tabulated results; while the medical fraternity will be satisfied with noting the conclusions reached, namely, that a much smaller amount of proteid food than is ordinarily consumed suffices for the daily needs of the body.

While Chittenden's work is being already utilized by scientific medical practitioners in their hospital work, notably in Boston, Baltimore and New York, and is being studied with advantage by hospital dietitians generally, its wider influence will not be felt until its principles are adopted in the hotel, the restaurant and the home.

The influence of the work of Chittenden is being felt throughout the whole of America; and that of his German confreres is having a decidedly practical demonstration in Germany during that nation's awful crisis.

Homans' Automobile Handbook. The gasoline motor car, with full description of the essential parts and auxiliaries and directions for its management, operation and care. By J. E. HOMANS, author of "Self-Propelled Vehicles," etc. New York, Sully & Kleinteich.

Many physicians are natural mechanics. To them this book will be exceedingly interesting. To the balance of the profession who, like the writer, do not profess to understand much about an engine, and when their car stalls leave it on the road, Mr. Homans' work will be most helpful and will many a time save the employing of a mechanic at eighty cents an hour, plus a liberal tip.

Surgical and Gynecological Nursing. By EDWARD MASON PARKER, M.D., F.A.C.S., Surgeon of Providence Hospital, Washington, D.C., and SCOTT DUDLEY BRECKINRIDGE, M.D., F.A.C.S., Gynecologist to Providence Hospital, Washington, D.C. The J. B. Lippencott Co., Philadelphia. Price, \$2.50.

This excellent book displays a serious and successful effort to put a vast amount of important information to nurses into a reasonable compass. The work properly emphasizes the primary factors underlying and complicating disease. The pathology is sound.

The chapter on observation by the nurse is very helpful, and that on measures to make the patient comfortable, valuable. Every nurse should study the doctrines of Anoci-association so well outlined here. The chapter on instruments is well illustrated, though the shiny surfaces do not show up the half lights on the black background as well as if it were white. The grouping of outfits for various operations and the place where they are to be used is very useful to the operating-room staff.

I think future editions would be improved by having specially important details in heavy type so they can be picked out quickly. The omission of Obstetrics as one of the branches

of the surgical specialties is obviously a slip. Greater stress should be laid on the dangers of strong mercurial solutions, especially as douches, and caution against purgatives in perineorrhaphy, especially after delivery. The details of preventing the tongue falling into the throat in a patient under anesthesia returned to the wards are inadequate, nor should sterile instruments be handled by a nurse without a mask.

These few errors but serve to contrast the general splendid outlook of the book.

Lateral Curvature of the Spine and Round Shoulders. By ROBERT W. LOVETT, Boston. Third Edition. P. Blakiston's Son & Co., Philadelphia.

This excellent monograph has now appeared in its third edition, and the reviewer ventures to predict that it will go through many more editions before it is replaced by anything better in English.

The features of the new edition include a chapter on the history of scoliosis, commencing with the coining of the word "scoliosis" by Hippocrates, and passing through all the stages of mechanical and gymnastic treatments of the various eras. In addition, there is considerable space devoted to the recent revival of the forcible corrective treatment advocated by Abbott.

But it is not upon new features that Lovett's work depends for its quality. From a scientific standpoint it would be hard to improve upon it. The chapters on the anatomy and pathology constitute the most authoritative and complete exposition of the subject in English. The chapters on treatment are complete, and while presenting most fully the personal views of the writer, they also present very fairly a description of the methods advocated and used by others.

The illustrations are excellent and abundant, and the book comprising over two hundred pages, is a credit to the publishers.

INTUSSUSCEPTION *

CLARENCE L. STARR, M.B., TORONTO.

INTESTINAL obstruction in a child under one year of age means in nearly all instances an intussusception. About 60 per cent. of all cases of intussusception admitted into any large clinic, such as the Children's Hospital, die. This mortality could be easily cut in half with the careful co-operation of the practitioners who see these cases at the commencement of the illness.

The average time of admission of all the cases of this sort during the past 15 years has been 57 hours, nearly two and one-half days after the onset of the trouble.

The easiest time to diagnose a case of intussusception is during the first 24 hours.

Once a diagnosis is made, no other treatment should be attempted before submitting patient for operation, as it has been definitely shown that no other method of treatment is of any avail.

The rather startling facts revealed by a record of the histories of these cases during a period covering the past 15 years is the basis for the conclusions drawn in this paper.

The cases number 46, with 31 deaths and 15 recoveries. The earliest case admitted was three hours after onset of symptoms, and the rest varied up to eight days. The average time of admission of the entire series was 57 hours, or nearly 2½ days after onset of symptoms.

The average admission time of the fatal cases was 74 hours, or a little over three days, and of the recovered cases 32 hours, or less than 1½ days after onset.

ETIOLOGY.

This condition comes on in apparently healthy children. In our series 30 were males and 16 females, but there seems no reason why one should be attacked more frequently than the other. The statistics of other clinics, however, show this same frequency in males, and there may be some difference in the

*Read at The Ontario Medical Association, Toronto, June 1916.

greater laxity of the mesentery in males. In no case which came to autopsy or where the operation would disclose the fact, was there any sign of polypus growth or foreign body. It seems reasonable to assume that these might be the causal factor, but, as a matter of fact, they are rarely found.

In most of our cases there was a history of intestinal disturbance, either marked constipation or diarrhea. These conditions, producing a congestion of a normally lax mucous membrane, may easily be the starting point of an invagination, which by the increased vermicular action of the wall readily becomes increased.

In support of the theory that intestinal congestion, especially in the region of the lower ileum where the Peyer's patches lend themselves to such congestion, is a large factor in the etiology is the fact that three-fourths of all the cases occurred in the summer months, when intestinal infections are most frequent.

PATHOLOGY.

The intussusception in the great majority of cases occurs at the ileocecal region. The large size of the colon, together with the greater degree of congestion from the swollen Peyer's patches and the great looseness of the mesentery and mesocolon, favors the possibility of telescoping in this region.

The mucous surface invaginates itself through the ileocecal valve, and then the active peristalsis carries this knuckle on into the ascending colon.

The ensheathing layer remains comparatively unchanged, even in the late stages, but this with the entering and returning layers form a mass which is the characteristic sausage-shaped tumor so often found.

The mass is enlarged by congestion and edema as the case progresses. Between the entering and returning layers the mesentery is carried in, and as the intussusception advances the mesentery becomes more and more stretched and causes the intussuscepted mass to curve on itself, with the concavity toward the spine. As a result of the stretching and pressure on the vessels of the mesentery, the circulation to the intussusception is gradually impaired. First the venous return is obstructed and engorgement and swelling take place, an exudate forms which

tends to agglutinate the surfaces between the entering and returning layers. Blood and mucus is poured out into the canal, and this is later passed by the anus, constituting the stools so characteristic of this affection.

As early as the end of twenty-four hours, so much congestion and agglutination may take place as to make it impossible to separate the entering and returning layers, and the mass becomes irreducible.

The longer this condition persists, the less is the prospect of reducing the invagination.

If the process continues, the arterial circulation is gradually cut off, and the intussusception becomes gangrenous, the part becomes invaded with bacterial organisms and a peritonitis ensues.

In some cases the intussusception has been known to slough off and pass by the anus, and the continuity of the canal be thus re-established. This must be exceedingly rare and has not yet happened in any of our cases, although a number of them have not been admitted until the seventh or eighth day of illness.

SYMPTOMS.

The sudden onset of acute symptoms in a child previously quite healthy is characteristic. The first clinical symptom is intense pain of a colicky nature, accompanied by signs of shock—sometimes amounting almost to collapse—pallor, cold, clammy skin, small thready pulse, with pinched features. Vomiting starts at once, and is frequently repeated, but even in the late stage rarely becomes fecal. These are soon followed by one, or even two, normal stools and within a couple of hours, during which time the pain has continued, accompanied by persistent straining or tenesmus, small frequent passages of blood-stained mucus take place. At this stage a tumor can usually be felt by palpation in the region of the hepatic flexure of the colon.

If the case is left, the other signs of intestinal obstruction follow, viz., gradually increasing distention and toxemia. By the end of 48 hours the symptoms begin to be covered up by the increasing distension and toxemia. The tumor may be masked by the fullness of the abdomen, and is no longer palpable. In some instances the apex of the intussusception may

have progressed so far on its vermicular way to the anus that it can be felt by the finger in a rectal examination, and this should never be omitted in any suspected case.

The increasing toxemia also dulls the sensibility of the child to pain, and this symptom largely disappears. The active straining or tenesmus gives way to a repeated series of grunts, not unlike the respiratory grunt of a case with pneumonia, and the patient becomes somnolent and apathetic.

DIAGNOSIS.

In a child under two years of age, the intensely acute onset, with pain, vomiting, collapse, one or two fecal stools, followed by straining and passage of blood and mucus, and possibly a palpable tumor, are characteristically diagnostic signs.

An acute appendix will not give the bloody stools or tenesmus, and any mass which forms will usually be later and found in the right iliac region, whereas in the tumor of intussusception, this region is palpably empty and the mass is up toward the liver or across the abdomen above the umbilicus.

In ileo-colitis the symptoms are more gradual in onset, and even if there is diarrhea with blood-stained mucus stools, there is always some fecal content and always bile present, whereas in intussusception no bile or bowel content passes after the first one or two stools.

With reasonable care the diagnosis can always be made within the first twelve hours, and with difficulty can it be made in the late stages, as the signs are gradually covered up.

TREATMENT.

Hitherto much valuable time has been wasted in attempting methods of treatment which obviously, from the nature of the condition, will be unavailing.

It may be said in a general way that with every hour which elapses the chances of the child's recovery are to that extent lessened; and the object of this paper is largely to impress the writer's conviction that a correct diagnosis should be made at the earliest possible moment, and at that time the child submitted for operative treatment.

If the patient is seen immediately after the acute onset of

the illness, there is no reason why an effort should not be made to disengage the telescoping portion of the intestine. It must be recognized, however, that this is only possible before any congestion and consequent edema of the intussusceptum has taken place.

The writer has in mind one distinct case where the child was sent in within an hour of the onset of symptoms, and there was a very definite mass palpable above the right iliac region. Under the palpating finger, while attempting to demonstrate it to a class of students, the tumor suddenly disappeared and the other symptoms subsided. This same child came in later, and similar palliative methods were tried, but without avail. The child was sent to the operating room, and under an anesthetic the tumor again disappeared by manipulation. So far, there has not been a recurrence of the condition. This must be a very exceptional case, but it demonstrates that within the first two or three hours after the onset of the illness it may be possible to undo the telescoping.

The methods usually suggested are: First, the inverting of the child, raising the hips high and almost standing the child on its head; second, the injections, per rectum, of water or salines. The old method of injecting metallic mercury is hardly to be advocated. In the same way the distension of the bowel with gas or air may be exceedingly dangerous. Again, I would like to emphasize that it is only within the first few hours that these methods should be attempted. When one has seen a number of these cases, it is apparent how readily the bowel can be perforated by any of these methods if adopted at other than the early stage.

If the patient presents itself within the first twenty-four hours, and in some instances at the end of the second twenty-four hours, it is usually possible to reduce the intussusception. An incision amply long to admit the whole hand should be made in the right rectus about the level of the umbilicus. After opening the peritoneum, the abdomen is readily explored and the mass located, usually in the right hypochondriac region. This mass, if possible, is brought out on to the surface of the abdomen without removing the rest of the intestines from the abdomen.

The reduction must be made with the utmost care, and should, for the most part, be squeezed back from above. Very little traction can be made on the entering bowel without the danger of tearing. Once the reduction is started, it is rapidly undone back to the last inch or two, and this must be patiently manipulated until it is completely straightened out.

The thickening of the wall from congestion and edema is usually sufficient to prevent recurrence of the condition, and it is rarely, if ever, necessary to stitch the bowel to the abdominal wall.

In case of failure to reduce the intussusception, the only thing that remains is to do a rapid re-section of the invaginated mass, and either bring the ends out of the abdominal wall, thus establishing an artificial anus, or close the ends and do a lateral anastomosis.

In the writer's opinion, the only re-section which offers hope of success is the one in which the ensheathing layer is stitched to the entering layer by a serous to serous suture, and then a longitudinal slit made through the ensheathing layer beyond this, the intussusceptum withdrawn through this opening and cut across close to the point where it turns in. A through to through suture may be put through all of these walls to strengthen the primary suture, and the longitudinal opening in the ensheathing layer closed by an ordinary Lembert suture. This must be rapidly done—and the time element is a very important one in the success of the operation.

Even in these cases, the patients frequently die of toxemia, unless some method can be devised of emptying the small bowel above the telescoped portion.

If the patient's condition is very bad, it may be better to remove the mass by a rapid re-section between intestinal clamps, and then bring both ends out on the wall by means of a Paul tube.

The mortality of re-section in these cases is extremely high, and every case in our series of this character ultimately died.

My thanks are due to Dr. E. A. McCowan, of the interne staff of the Hospital for Sick Children, for the details of the statistics from the hospital histories of the past fifteen years.

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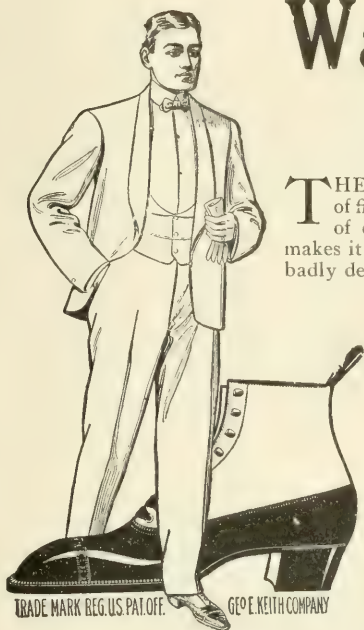
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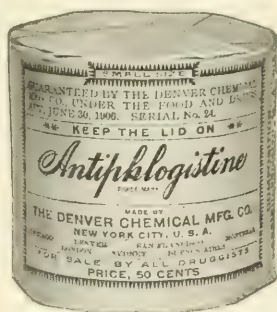
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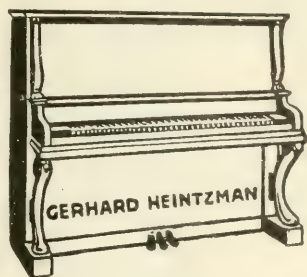
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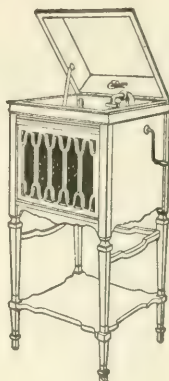
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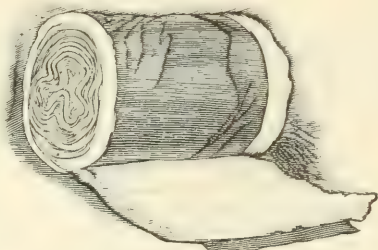
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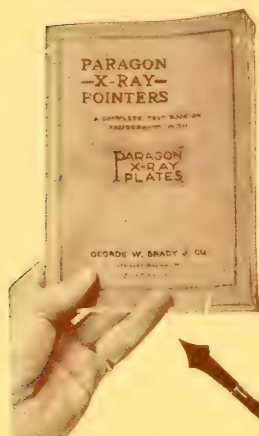
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No. 5

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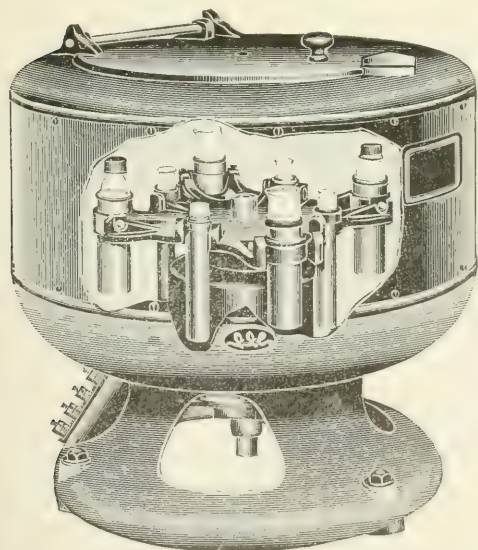
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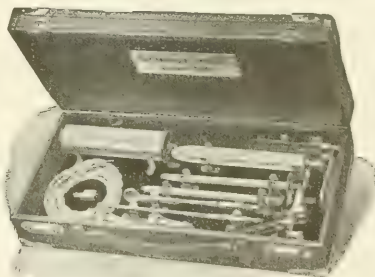
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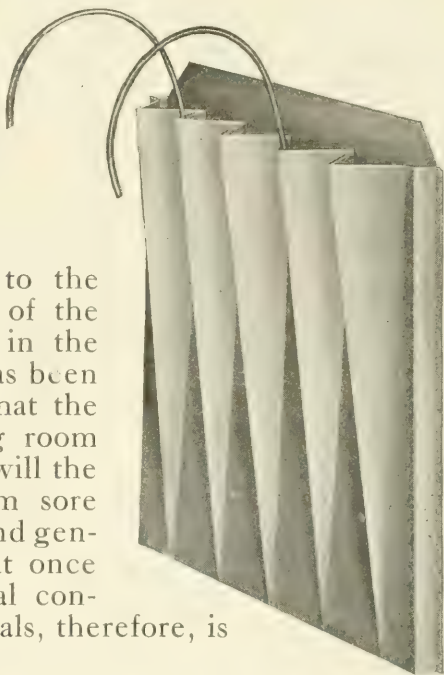
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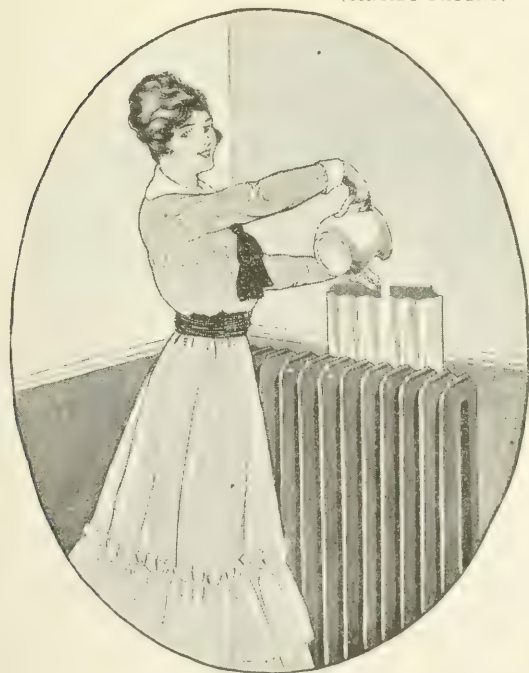
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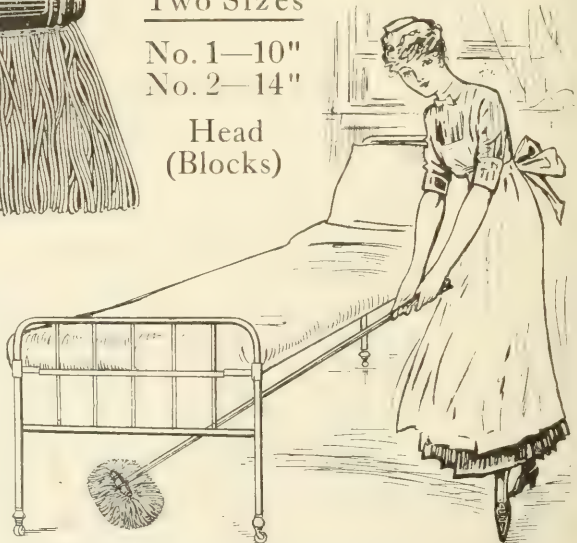
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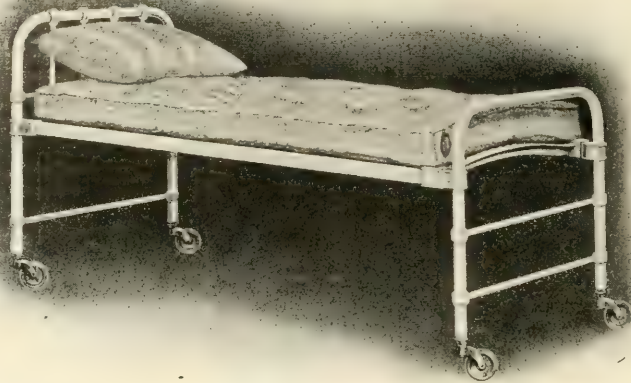
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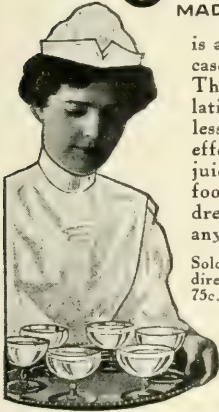
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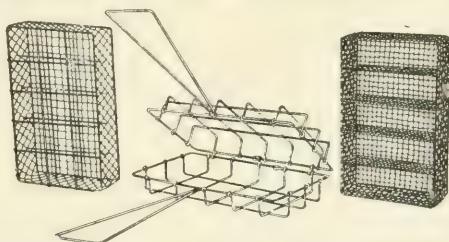
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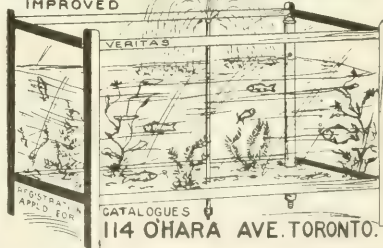
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Vol. X.

TORONTO, NOVEMBER, 1916

No. 5

Editorials

THE HOSPITAL AND THE MEDICAL PROFESSION

IT IS high time the hospitals and the medical profession began to do something in respect to their relationship. For many years would-be leaders in the

profession have jostled one another in order to secure appointments on some hospital staff. Hospitals have chosen men for their ability as practitioners, and men at the same time who would bring wealthy members of their clientele to the private wards of the hospital.

That class of patients whose payments for services rendered visibly swells the hospital income are welcomed by the hospital management as an offset to the loss sustained in caring for the patients who pay less than the per capita daily cost. The doctor who is able to bring the former class to the hospital to any extent is too quite often given a staff appointment in preference to a better man.

It is most unfortunate that many hospitals are not able to choose first-class men without regard to anything except professional skill and standing.

The time is arriving when the qualified man will no longer give his services gratis to the hospital; the lawyer does not; the butcher does not; nor does anyone else except, possibly, the chaplain, whose duties are very light.

Hospitals should give their physicians and surgeons a *quid pro quo* for services rendered, and it is time medical societies considered the question of remuneration and that the profession decided unitedly to demand pay for its work. It is only fair to themselves and their families.

The majority of medical men earn only a moderate income. They are obliged to keep up appearances; have a good house; well-appointed offices;

and complete modern equipment (which alone means a large expense). They need vacations, and regular trips to large medical centres for post-graduate work are absolutely essential.

All these things cost money, and the community the doctor serves should properly remunerate him for the service he gives.

House officers have always worked hitherto for the experience gained. We are glad to note they are coming slowly to their own in the matter of remuneration. A number of hospitals are allowing internes \$200 and \$300 a year in addition to living expenses. This is inadequate. After five years of heavy expenditure in securing his medical education an interne needs money and deserves a fair salary. His case should be considered together with that of his senior by the medical associations when this important and vital subject shall be considered by them.

HOSPITAL EMPLOYEES

HOSPITAL employees should not be permanently engaged until they have been examined physically by a competent member of the medical staff. A report of the examiner should be filed.

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pital, rate of pay, age, whether married or single or divorced, number of dependants and financial status.

The employee should be well paid, have his work definitely assigned, be properly supervised and kindly treated. He should be informed that he will be promoted in rank or given an increase in pay if his work is satisfactory.

It is pleasing to learn that certain hospitals are providing pensions for employees who have given long and faithful service. In the majority of hospitals the transient tenure of office of the average orderly or cleaner is painfully short. Small pay, inconsiderate usage, and general restlessness are the main causes. Such a condition of affairs is bad for the hospital and bad for the worker.

Since the work in a hospital carries a peculiar strain, employees should be encouraged in every possible way. In addition to good pay, they should be provided with comfortable quarters, recreation rooms, eight hours of work daily, at least three weeks' vacation yearly, and considerate treatment generally from their superiors.

In case an employee is discharged or asks for his discharge a slip should be handed in containing the date, name, department, rate, statement as to whether services were good, medium or poor, and the reason for the retirement.

It is desirable that every head of department carefully consider the matter of discharging any employee under his jurisdiction. Before doing so it would be well for him to give the employee every

opportunity to make good. If he finds the individual inefficient, or careless, or incompatible he should endeavor in a firm and kindly manner to teach him to do better. That failing, he might recommend his transfer to another department for which perhaps he has expressed preference or where he will come into a changed environment in the matter of fellow-workers or chief. This is often a successful move.

The head of a department should remember that the worker is his brother. He cannot go far wrong if, in dealing with a subordinate, he always keeps in mind the Golden Rule.

Original Contributions

EFFECTS ON PROGNOSIS ON THE MANNER OF ADMINISTRATION OF ANESTHETICS *

P. E. DOOLITTLE, M.D., TORONTO.

"The operation was successful, but the patient died." This dig at the surgeon is sometimes misdirected, and occasionally it might be changed to, "The surgeon was skilful, but the anesthetist was not, and the patient died." In grave operations on patients already weakened through prolonged illness or septic absorption the shock of the anesthetic may be the determining factor that turns the tide against the patient. The patient with a short, thick neck who, under ether, chokes up under the combined effects of abundant mucus secretion and a nearly closed glottis, suffers from partial asphyxiation, which in a prolonged operation adds greatly to the chances against recovery. So also the same patient who is alternately asphyxiated and resuscitated gets a series of shocks that add to the danger, while the delay to the surgeon by these alternating conditions further prolongs the operation and adds to the danger. When such a condition arises, the change to chloroform will usually promptly check the secretions and permit the surgeon to quickly complete his work, to the great advantage of the patient's chance of recovery.

And not only is it a case of danger to the life of the patient, but in some operations the behavior of the patient subsequent to the operation determines its success or failure. As an example, take an old standing umbilical hernia. Here there is often not only a large space to close up, but frequently atrophy of the adjacent abdominal walls renders a good strong adaptation a matter of great difficulty. Frequently the completed operation leaves an abdominal wound under extreme tension, and with the stitches holding in very insecure tissue. Violent retching, straining and delirium in coming out of

* Read before The Academy of Medicine, Toronto.

the anesthetic frequently undo the good work of the surgeon, and the last state of the patient is far worse than the first, with the chances of a subsequent operation being successful being much less likely than before. The patient who is suddenly dosed with an overpowering amount of ether or chloroform becomes frightened, struggles, and frequently has to be held on the table till the anesthetic is pushed to unconsciousness. Under these conditions the patient's first conscious moments will be in terror and fright, and straining is bound to result. Such a patient should be quietly talked to by the anesthetist, who is frequently a total stranger to him, and a feeling of perfect confidence and understanding be arrived at before beginning the anesthetic, and a few minutes spent in this way is of immense value in a favorable prognosis. When the patient's confidence and trust are fully established, a few drops of chloroform or a little ethel-chloride should be placed on the mask, and, still keeping the patient's attention fully, pleasantly occupied (if you find he has a hobby talk that), hold the mask far enough away from his face that he first only faintly gets the vapor. Then gradually lower it, adding small quantities of the anesthetic till the patient gets drowsy and fails to answer questions, when the mask can be applied and the ether cautiously begun without the patient being aware of the change. Under this method the patient wakes after his operation in a quiet frame of mind and without delirium.

Lastly, always remember that your part of the work is of the utmost importance, and not even second to that of the surgeon. Concentrate your whole attention on the patient, only being sufficiently conscious of what the surgeon is doing to enable you to lessen or increase the depth of the anesthetic according to the surgeon's needs and the patient's safety, but never let the patient become sensitive to the operator, which would add to the shock; and give the least possible amount of the anesthetic that will give the desired result.

619 Sherbourne St.

THE WORK OF THE STAFF *

BY PATIENCE EISENIERS.

For the benefit of either lazy or industrious people who may be thinking of taking up hospital work, some information about the duties of various positions may be of interest.

The superintendent's are quite weighty. He need not necessarily be a doctor; but, layman or physician, he must have a keen eye, not for bacteria, but for mazuma. Any superintendent who can wash enough sterile gauze to make one yard do the work of two is the well-beloved of the trustees. He has an eagle eye for the absence of rubber heels and can see at a glance if the door of the ice-box is tightly closed, or whether the flies have found a new port of entry.

In financial matters he is expected to be as tight as a wet clothesline. He must see that no employee puts anything over on him, and that no patient escapes to the open without the O.K. of the bookkeeper. The principal of the Nurses Training School acts as a prophylactic against Cupid's darts. She sees to it that loitering internes are promptly put to flight. All good looking nurses must have their curly locks slicked down till they resemble skinned rabbits. By thus putting promptly all rivals out of business, this lady often secures the most desirable staff doctor for herself.

The duty of a nurse, either pupil or graduate, is to let patients know where they get off at. To the trained mind all patients are as nutty as a fruit cake. They must be ruled with an iron hand, and no attention should be paid to their whims or desires. Nurses do not like patients who whine, patients who are nervous or hysterical, patients who are helpless or who require a great deal of waiting on, in fact, it would seem as if a number of them do not like any kind of a patient at all.

There is no use arguing with a nurse. In a contest between a helpless patient and able-bodied nurse, the nurse always wins out.

The duty of the house doctor is to act as maid of honor to some Big Chief and imitate, to the best of his histrionic ability, the chief's supernatural dignity. His face must be a faithful

* Written specially for *The Hospital World*.

reflex of the chief's emotions. To smile or laugh when the chief's face registers concentrated thought or deep concern is a fatal blunder.

The interne usually begins as an ambulance surgeon at which stage his duty is to see that he keeps the muscles of his back and arms in a supple condition. In those hospitals which own the cap worn by the ambulance surgeon, it is believed that candidates whose heads fit the hat are preferred above the other applicants.

All house doctors are natural born collectors. In their rounds they collect sandwiches, candy, magazines, liquid refreshments, and, in fact, they will collect anything that is not nailed down.

The duty of the driver of the ambulance is to deliver the patients at their own door in a state of delirious joy that their break-neck journey over chickens, men, holes, torn-up streets, dogs and pedestrians has not ended fatally. At the end of the journey it is the duty of the driver and the surgeon to beat each other to the easiest end of the stretcher. The relations between these two are always genial and pleasant, somewhat like those between the burglar and a Pinkerton.

An orderly owes no duty to anyone but himself. His duty to himself requires him to hunt up a snug retreat in which to while away his time. Should some sleuth root him out of his lair in the basement, he can instantly find a better one. Some sixth sense warns him when his services are required, and he immediately steps over into the fourth dimension.

A chambermaid acts as the official "Who's Who," for the benefit of the patient's curiosity. She can tell what is the matter with the mysterious man in No. 7, and the latest eccentricity of the old lady in No. 2. The first thing in the morning you learn about who has died in the night. Her ambition is to see if she can spend three-quarters of her time gossiping with the patients and get away with it.

Finally we come to the duty of the patient. Dead easy. Any hospital superintendent can show you in black and white that the institution is losing from six cents to two dollars and nineteen and one-half cents per diem off of each patient.

It stands to reason that the only favor a patient can do a

hospital is to pay his bill and "beat it" as fast as an ambulance, a taxi, or a street car can take him.

The duty of the hall man is to work upon and so perfect his schedule that his dust-raising duties will exactly synchronize with the passing of meal trays. He is always on friendly terms with the chambermaid, their mutual dislike of the nurses forming a close bond of sympathy between them.

THE HOSPITAL FROM A PATIENT'S STANDPOINT*

BY PATIENCE EISENIERS.

Why is a hospital? What is the cause of so many complaints and so much dissatisfaction among the patients in a hospital—not any particular hospital, but just any and every old hospital. It requires but the chance encounter of two patients in any conveniently isolated spot to start an immediate session of the knocker's club. It is all due to their misconception of the functions of a hospital. A hospital is not a place for a sick person to be comfortable in, any more than the inside of a casket or the unyielding top of an operating table. Only the well and strong can force their way to comfort. The most a sick person can hope for is a minimum of discomfort.

A great deal of irritation could be avoided if patients would wait patiently for their sentences to expire, and stop expecting what never was and never will be. How can one expect a nurse when she has anywhere from four to ten people to look after, to spend her time massaging the punctures in your ears so they won't grow shut while your diamond earrings are reposing in the office safe. Be thankful, rather, during a busy day, if you get your face washed when the night nurse comes on duty. Don't expect a nurse to read to you, or amuse you in any way, as you can always amuse yourself by watching the antics of the mouse in your room. Every hospital room contains at least one thoroughly domesticated mouse, who lives back of the steam

* Written specially for *The Hospital World*.

pipes and appears to be learning the plumbing trade in a night school, or, you can close your eyes and refurnish your room.

A private room in a hospital, furnished by a donor will not be likely to contain more than six square inches of floor space, unobstructed by some kind of flub-dubs. The price of the room varies directly as the heft of the furniture, you will not have much of a view, as some kind of hospital psychology always locates the bed in the loneliest part of the room.

If you are in one of the ultra-modern type, exemplifying the last word in cubist hospital architecture, you can gaze at the futurist doors and fire-places and anemic color scheme and console yourself that well—anyway—it looks as if it might be fireproof. They certainly all have acoustic properties, carried to the nth degree. If the managers of Billy Sunday's campaign wish to improve on his wonderful sounding board they could do it by renting an abandoned hospital. Nowhere else will a hall clock tick so loudly through a night of insomnia or falling dishes spin around so many times on a tiled floor; nowhere else are scrubbing brushes plied with such unbelievable polish enthusiasm at daybreak; nowhere else would a nurse's cot squeak so poignantly or the whispered flirtation at the nurses' table between some interne and the night nurse reach your ear so piercingly. Of course, you would not mind this so much if you could only hear quite clearly just what they were saying to each other.

Should you require the services of a house doctor, you can save much time by knowing the location of the prettiest nurse, and sending for him there directly—flirting, eating and sleeping, in the order mentioned, being an interne's favorite methods of diverting his mind during the tedious hours before the arrival of his day off duty. It is hard to get them to do anything really useful, such as swatting flies, or lending a hand here and there on a heavy lift. The only load they ever carry cheerfully is sometimes acquired from the private stock of some patient, whose physician allows him a supply of the stuff that made Milwaukee and St. Louis famous. Internes are responsible for many caustic comments of patients on the sharky tricks of purveyors of grape juice, champagne and other liquids who give such amazingly short measure, as short, to a patient's point

of view, as the comfort-purchasing ability of what he is taxed for his board and room in the hospital.

It can be proved in actual figures that the hospital gives you as much, if not more, than you are paying for, but it is hard to make a patient believe that his dollars purchase so little. Anyone paying \$25 per week or more, in a hospital, expects the nursing service of Dr. Bull's \$100 per week sanatorium, the accommodations of the Waldorf-Astoria, and the cuisine of the Ritz-Carleton. Visit him at the end of a week and he will tell you confidentially, that in his opinion, he is getting the nursing service of the Belgian trenches, the accommodations of a Mills hotel, and the bill-of-fare of a McGregor mission. He has a vague idea that the government ought to be seeing about such things.

However, he is wrong, you can get anything you want in a hospital—on one condition—you must be careful not to want anything.

HOSPITAL EATS *

BY PATIENCE EISENIERS.

My son, hear the instruction of thy Uncle Fuller, and permit him to wise thee up in hospital cookery, that it mayest go well with thee as chef, and that thou wastest nix from the hospital's substance.

For food—these days—is more precious than rubies and must be paid for with fine gold and silver and much hidden treasure.

Be ye, therefore, a tight-wad in all thou dolest out, and attend carefully to the attenuation of all liquids on thy bill-of-fare.

Make thou frequent journeys to thy cistern and spare not in drawing from thy well in the corner.

For on thy watery additions to thy soup, milk, tea and coffee kettles dependeth their ability to hold out even unto the setting of the last table.

* Written specially for *The Hospital World*.

That thou mayest forestall their kicks and complaints, which are as a thorn in thy side, serve thou the first attenuation to those knockers who occupy the private rooms.

Wearry not in thy dumping-in from thy water bucket and serve thy next attenuation to the barbarians within the walls of thy wards.

Discretion shall preserve thee that thou servest thy attenuations to the house staff in the proper order of social precedence, the principal of the training school, the resident physician, the internes, the nurses, the orderlies—even to the thirtieth attenuation thou servest the helps' table in the basement.

Regard not their scorn and revilings, for is not any grub good enough for the sustenance of these rough-necks?

He becometh poor that dealeth with a slack hand, therefore be not too flossy in dealing with thy hospital's chickens.

For on thy discretion dependeth the ability of one lonesome chicken to lend a spurious flavor to many dishes.

Waste not thy chicklet's strength within the soup pot; rather encase his legs in rubber boots and walk him swiftly through thy kettle.

Cast out the mocker who revileth thee with the name of "cheap skate," he who claimeth there is no chicken flavor to thy bouillon.

Even as a precious jewel in a pig's snout are those slanderers, they who say all hospital chickens have atrophy of the breast muscles and hypertrophy of the neck.

Sharpen, therefore, thy hatchet like a two-edged sword, that each receiveth his molecule of chicken, and gather ye up the remnants even to the tiniest sublaxation.

For of such mayest thou bring forth the next day thy chicken pot-pie, in ramekins.

Even here thou canst confound the sceptics who believe not in the presence of thy long gone, but not forgotten, chicklet.

Thou canst insert beneath each upper crust a tiny chicken-feather.

Thus wilt thou have thine enemy upon the hip; he can prove nothing. What carest thou for the revilings of the gluttonous; it is their favorite indoor sport. They are like the horse leech's daughter, crying, "Give, give."

And, further, my son, by these be admonished, of the combinations of hospital salads there is no end; and much study in their construction is a weariness to the flesh. Therefore, store up thine odds and ends of vegetables, fruits and animals into the making of a perfect "Review of Reviews." Thou shouldst worry as to harmonies of taste and subtle flavors. Rather evolved lobskosh weirdly composed of oranges and onions, dill pickles, cheese and wienerwurst. And that it may not seem too raw a handout, doll up the top with whipped cream and a cherry.

The sun ariseth and the sun goeth down; but this recipe for lobster salad remaineth on the job.

Let the proportion be 8 to 1. Eight large, round heads of cabbage, finely chopped, to one of lobsters, smallest size.

In thy discretion should this seem too many lobsters, split the can—fifty, fifty.

For why encourage this set of pikers to develop costly tastes. Should thy whole day be spent in serving lobsters?

Verily, from the first breakfast to the last supper it seemeth like doing nothing else. As for thy salt and pepper shakers, steer no middle course.

Either put thou in none at all, or go thou the limit, even unto the sky. They to whom thou caterest be a perverse and stiff-necked bunch. They love to bawl thee out and say thy food hath in it no savor of spikenard and saffron, calamus, cinnamon and all the chief spices. What need be there of extra seasoning when penetrating all is the sub-acute flavor of the chemical refrigerator?

My son, be not afraid of the desolation of the fault-finders. They cannot get thy number.

So that thou standest well with him who payeth the grub bills, thou shalt find favor and good understanding in the sight of God and man. Selah.

Society Proceedings

AMERICAN HOSPITAL ASSOCIATION

THE Philadelphia meeting, held during the last week in September, was a great success—over 1,000 being present on the first day. The East was well represented, the Middle-west fairly, a handful from the South, and scarce a soul from the Far-west.

Eight hundred lunched at the Pennsylvania Hospital, the guests of Mr. and Mrs. Daniel Test. Beside the luncheon, there were auto drives to points of interest, a trip to Valley Forge and a complimentary vaudeville entertainment at Keith's theatre. Never were the members better looked after.

The next meeting will be in Cleveland, and Dr. W. J. Wilson, Superintendent of the Wellard Parker Hospital, will preside. Dr. Wilson has taken a live interest in the Association for some years, contributing on several occasions papers on every aspect of work in contagious hospitals. He contributed one at the Philadelphia meeting.

While the hospital world has been getting away from the old ideas of fumigating with sulphur and formaldehyde, he comes out in his paper, endorsing their use.

Here is what he says:

“Determine cubic area of room. Fill all cracks, crevices, and openings of every kind by pasting paper over them, so as to make the room as near gas-tight as possible.

“If sulphur is used as the disinfectant, 4 pounds of finely cracked brimstone for every 1,000 cubic feet of area to be disinfected is put in an iron pan or pot. This sulphur receptacle should be placed on a brick in a dish pan containing water two inches in depth. The dish pan is placed on a number of bricks on the floor to ensure protection against fire. The water not only serves as a protection against fire, but gives the moisture necessary to produce the disinfection. To start the sulphur burning, a little of it on the top and in the centre of the pan

is made finely granular and a little wood alcohol poured on it and ignited.

"This method is applicable not only for killing bacteria, but is especially useful in getting rid of lice, bedbugs and other insects.

"If formaldehyde is chosen as a disinfectant, it may be generated as follows, using 10 ounces of a forty per cent. solution for every 1,000 cubic feet of area to be disinfected. Immediately before using, add 1 ounce of commercial sulphuric acid to 10 ounces of 40 per cent. formaldehyde solution, and pour this mixture on 1 pound of unslaked lime. The gas will be immediately evolved. Care must be taken in handling the sulphuric acid, as careless handling may result in a serious burn."

Dr. Wilson maintains that these formulæ will do the work.

Miss Emma Anderson presented the report of the committee on the grading and classification of nurses. The report is a comprehensive study of the nursing problem, with especial reference to the need of more nurses trained to care for certain specific diseases, to the need of maintaining proper and reasonable standards and to the care of the sick in the homes of families of moderate and small incomes. But "devil a word" does it say about the grading of nurses.

The pussyfooters did not want to stir up a hornets' nest. The damp blanket was effectually used to quench the incipient flames, and all is harmony.

An attempt was made to make the *Modern Hospital* the organ of the Association. Dr. R. R. Ross, of Buffalo, brought in the recommendation. Dr. Howell Wright supported the idea. Miss C. A. Aiken, editor of the *Trained Nurse*, averred that the Association should not have any official organ unless the Association controlled the policy of the organ.

Trustee Borden, of Fall River, said, "It seems to me that no business concern would go into a proposition of this kind without ascertaining very distinctly what the party of the second part was willing to do."

The matter was referred to the new Board of Trustees, Dr. Winford Smith, Miss Mary Keith and Mr. Borden, of

Fall River, together with President Wilson, Treasurer Asa Balm.

The new secretary is Dr. Walsh, late of the Contagious Hospital, Philadelphia. His opponent was Mr. Wright of Cleveland, secretary of the Ohio Hospital Association. Wright's candidature had been planned, but Walsh had done yeoman service for the Philadelphia meeting and won out.

A permanent headquarters is to be established on or before July 1st, 1917. It is up to Walsh. The commercial exhibit brought in some \$3,000. If this record can be kept up it will be possible to maintain a headquarters and a permanent secretary.

The constitution and by-laws have been amended.

Besides the formation of a Board of Trustees, and the recommendation of the establishment of permanent headquarters, heads of departments are admitted as associates and assistant superintendents may become active members. A committee on necrology has been arranged for.

The annual address was given by Dr. Winford H. Smith. He was not surprised that the Association had not grown as rapidly as was expected, following the eligibility of trustees and superintendents of nurses to membership. Trustees were too busy and superintendents of nurses had organizations of their own. Many superintendents were unable to attend on account of the expense. It might be well to have an Eastern, a Western, a Central, a Southern and a Canadian Association, each meeting every two years on its own territory; the American Hospital Association to meet on the alternate years. Dr. Smith had another suggestion, that the American Hospital Association, the American Public Health Association, the National Association for the Study and Prevention of Tuberculosis, the American Sanitarium Association, and similar associations, unite as a large American Public Health Association—each association to preserve its own identity as a section of the larger body.

Dr. Smith recommended the discontinuance of the committee on hospital progress, which includes eight sub-committees. The number of committee reports, in his opinion, interferes with the preparation of a well-balanced programme. He endorsed

the proposal of Ex-President Howell, that a Council of a House of Delegates be appointed.

The essayist regretted that so many hospitals had been established as a result of misguided enthusiasm, without proper financial backing. A high standard was being exacted, necessitating better nursing, more refined methods of diagnosis, and larger medical and surgical services. As a result of this mushroom growth of hospitals, salaries and wages paid were altogether too small. Trustees seemed to forget that a cheap man was the most expensive in the end. So standards of decorum and morals are often so low as to amount to scandal.

As to medical staff appointments, the continuous system was much more satisfactory than the rotating, but difficult to establish in small community hospitals. Merit should be the only basis of appointment or advancement.

Modern medicine and surgery demanded greater laboratory facilities than most hospitals were providing. Too little attention is paid to autopsy findings.

Stress was laid by Dr. Smith on the giving of anesthetics by a well-trained person. In too many hospitals this procedure was faulty.

Hospitals were becoming to be more than repair shops—with their social service, their pay clinics, they were having a broader relationship to the community.

Dr. Smith strongly emphasized the importance of making the superintendent the one avenue of communication between the sub-departments and the Board of Trustees.

In projecting new hospitals, greater attention should be paid to community needs. There should be some agency to co-relate hospital development and community needs.

Mr. Michael Davis recommends a hospital for each 100,000 of the population.

Emphasis was laid on the importance of better municipal hospitals. They should be entirely divorced from the evils of political domination.

These city institutions should have branches in the country for convalescents. This would make for economy.

Hospitals owed a duty to the physically handicapped. Dr. Hall, at Marblehead, and the Burke Foundation were leading the

way. We would learn much about what was best to do by observing how the various militant countries handled the problem of the disabled soldier.

Hospitals, from being places of resort for the indigent only, now are found to be the best place for the wealthy. As a consequence, more attention must be paid to furnishings.

One of the great needs of to-day is a hospital service for the middle class. The American Association ought to show how this need can be met.

Dr. Smith pleaded for the higher and broader education of nurses, and quoted Dr. Walsh as advocating that the philanthropically inclined might well give large endowments for that purpose. The nursing profession was intertwined with the medical, stood by its side and was not subservient to it.

In too many hospitals the out-patient department was too often considered as a side issue—the patient did not get fair play—examinations of him were too cursory and “skimpy.” This service demanded the highest grade of work.

Clinics should be established for venereal diseases, and much attention should be given to the matter of preventing their spread.

Hospitals should not countenance the separation of the mother from her illegitimate child. Ninety per cent. of such children died.

Miss Mary Riddle, of the Newton Hospital, holds that the smaller hospitals in the United States are in dire need of expert business men and efficient executive organization, and that the average physician superintendent of the smaller hospitals lacks the necessary business instinct.

The average small hospital, it was pointed out, fails in its curative purposes of disease, infection and the general illness of humanity owing to the lack of proper scientific instruments, poor laboratories and the absence of hygienic kitchen and dietary cuisine. The hospital, whether large or small, she declared, should be one of the leading educational influences of any community, but it is a well-established fact that some of the smaller institutions are often so poor that they do not even possess a copy of any pathological literature and sometimes are even in need of an unabridged dictionary.

Dr. J. M. Baldy, of 2219 Delancey Street, who said that

while he was not a member of the association, he deplored the present condition of the smaller hospitals. He declared that the salvation of those institutions rested with the young members of the staff.

Bad teeth cause a large percentage of heart disease, liver trouble, kidney disease, ulcers of the stomach and eye trouble, according to Dr. Thomas B. Hartzell, of the University Hospital in Minneapolis. Dr. Hartzell gave an illustrated lecture on Dental Clinics in General Hospitals before the American Hospital Association on the roof of the Bellevue.

"Seventy-five per cent. of all heart disease and a large proportion of kidney disease are due to streptococci viridens," said Dr. Hartzell. "A large proportion of these streptococci come from the teeth and are swept into the stomach by the food or get into the blood from ulceration."

The speaker defined "proper care" as a scrubbing vigorous enough to leave the teeth shining like porcelain and a rubbing of the gums with dry cotton, following by rinsing with warm water. He recommended that every general hospital employ at least one dental interne, aided by one trained nurse, and provide a special room for the work.

"The human mouth is the great gateway for infection to the body. Human teeth scrapings from healthy mouths show from six to eight million bacteria per milligram, and the percentage from diseased mouths rises to a hundred million. In some cases the bacteria double in numbers within thirty minutes, and gather on from twenty to thirty square inches of tooth surface.

"Bad teeth may affect the heart, joints, brain, kidneys and stomach. Abscessed teeth have caused inflammatory rheumatism symptoms, and in one instance a man with a healthy heart who refused to have his teeth treated was found some months later to have a distinct heart 'murmur' and ulcers."

The convention meets next year in Cleveland, Ohio. Most of the forenoon session was taken up with changes in constitution and by-laws. Richard P. Borden, trustee of the Union Hospital, Fall River, Mass., recommended the appointment of a permanent paid secretary, to establish a bureau of hospital information and a headquarters. This suggestion was adopted, the headquarters to open not later than July 1, 1917.

(To be continued.)

Selected Articles

THE OPERATING ROOM BUILDING OF THE HENRY FORD HOSPITAL

BY JOHN N. E. BROWN.

Medical Superintendent, Henry Ford Hospital, Detroit, Mich.

THE operating building of the Henry Ford Hospital is a brick building of one story in height and 125 feet long. It has four complete operating suites and also a dark operating room. One of the suites contains an operating room (30 ft. x 27 ft. x 18 ft.) capable of seating sixty spectators.

A corridor runs the whole length of the building, on one side of which are the operating suites; on the other side are surgeons' offices, lockers, shower rooms, examining room, an instrument room, telephone booth, and a laboratory for making quick sections. This corridor serves as a line beyond which the public is not allowed to go in the direction of the operating suites.

One end of this long corridor is cut off for the reception of emergency cases. From this cut-off portion of the corridor entry is made by two doors into two preparation rooms, respectively.

Four of the operating suites lie side by side, except that between each of the two end suites, there is a sterilizing room, in which are sterilized dressings, utensils, instruments and gloves—a separate sterilizer being used for each of these.

The water sterilization is carried out in the attic in two sterilizers of 250 gallons' capacity each. In the same room in the attic there is a still. The sterilized water is conveyed down in pipes to a lavatory in each operating room and also to a lavatory in each sterilizing room. Each of these lavatories is provided with an elbow valve, by the swinging of which either cold or hot water, or a mixture of both, may be secured. Ade-

quate provision is made for the sterilization by steam of pipes and faucets.

Each operating suite consists of three rooms—two of the rooms lie adjacent to the long corridor, being connected with it by doors. One of these rooms is used for the administration of the anesthetic (10 ft. x 12 ft.) and is provided with a blanket warmer and a lavatory room. The other room (7 ft. x 12 ft.) is a surgeon's scrub-up and connected by doorway without a door with the operating-room. It has three lavatories, thus enabling the surgeon-in-chief, his assistant, and interne to wash up at the same time. The soap used in these scrub-up rooms is liquid in character, and is contained in a metallic box, the surface of which is flush with the wall. A projecting faucet is provided with a valve which is controlled by action of the knee. The surgeon, by pressure of the knee, can secure the desired amount of soap in his outspread hands and upon relaxation of the pressure, the valve closes automatically. The control of this soap apparatus is electrical in character.

The third room of each suite is the operating room. All the operating rooms have tile walls and ceilings throughout. The floors of the operating rooms, as well as the whole building, are of tile—vitrified. In three of the operating rooms the tile walls are moss green in color up to a height of about ten feet. Above this they are white. The walls of the fourth general operating room and of the two accessory rooms—the anesthetic room and scrub-up room—are of gray tile.

The operating rooms are lighted by means of windows in the north wall and in the ceiling. The wall window occupies about half of the north wall space of the room, while the roof and ceiling lights correspond to about four-fifths of the ceiling. The ceiling lights are of glass as are also the roof lights. In the space between them a sufficient number of nitrogen lamps are suspended which, when lighted, afford ample light for operating at night. In all the operating rooms, sockets are left to enable operators to secure lights for local work.

The gynecological operating room is provided with a trench in which three or four onlookers may stand to peer over the sitting operator, who may be performing operations by the lower route.

The nurses are provided with four rooms. The head nurse is given an office at the entrance near the surgeon's offices; and three other rooms are provided en suite directly in the centre of the working portion of the building—that is, in the operating portion. The largest room is the nurses' work-room, which has cabinets in the wall and on the floor for supplies. In this room is a reservoir for distilling water, connected by pipe with the still in the attic. In an alcove off this room is an autoclave whose doors are flush with the wall. In this autoclave the flasks containing salt solutions are kept at a little above body temperature, the temperature being automatically controlled. Off this large room is a nurse's retiring room in which she may dress, or rest, if necessary. It is provided with the necessary lavatory and toilet accommodations.

The largest operating room has seats arranged in amphitheatre style which are made of cement, excepting the seat proper, which is made of cork. At the back of the amphitheatre is a door from the outside through which the students have access down to the basement where their lockers are, and up to a room at the back of the top row of seats where they may gown before descending to their places around the arena. At the opposite side of the same circular seats is a door through which visiting doctors enter the amphitheatre, and here there is a corresponding room to that used by the students, where these visitors may gown.

The three other day operating rooms are 21 ft. x 17 ft. All are 18 feet high.

Electrically controlled clocks are provided in all operating rooms, except the dark operating room. Washed warmed air is forced at a slow rate into the building through openings near the floor, and sucked out by means of fans in the attic through openings near the ceiling.

The cost of this operating room building was approximately \$100,000. — *The Trained Nurse*.

THE NEED FOR PROPERLY TRAINED ROENTGENOLOGISTS

THE activity of the various instrument makers in filling the demand for X-ray apparatus to equip the numerous new hospitals throughout this land, has created a large number of openings for competent roentgen workers. Scores and scores of hospitals have gone ahead with the purchase and installation of expensive roentgen equipment without serious consideration of the question as to who should make use of the attractive instruments. When one comes to realize it, it is a strange thing that no more mature thought is given the selection of the roentgenologist himself. Many hospital authorities seem to feel that the filling of this position will be simple enough provided the equipment installed is of the latest type and highest kilowatt rating, and if it includes a transformer of the open or closed core type, according to the persuasiveness of the salesman who finally landed the contract.

The real practice of roentgenology begins when the roentgenogram or the roentgenoscopic image has been produced. No matter how expert one may be in the technical side of the production of the plate or screen image, once that image has been produced he is still helpless as far as the practice of roentgenology is concerned unless he has had a certain training, and a certain amount of experience, the more the better. This work can no more be performed by the non-medical individual than can stethoscopy or percussion of the chest by one not medically trained. And the medical training even is not sufficient: there must be special training in the interpretation of roentgen shadows.

There is a real field and a rare opportunity for medical men with proper clinical training to enter the field of roentgen diagnostics. Every medical man engaged in X-ray work is receiving just that amount of recognition and respect from his colleagues which his abilities have carved out for him. The trouble is that there are so many attempting this work who are inadequately equipped for the task. For each available competent roentgenologist, there are at least five hospitals clamoring

for proper X-ray work, of the kind done in our best-known medical centres where roentgenology has been given its proper place among the other major medical sciences. The result is that the four hospitals for whom there is not available a competent man, do what in their opinion is the next best thing—they put in an incompetent, and invest him with an authority which he has not earned and which does not really belong to him. Does he not operate the same kind of X-ray apparatus as the well-known Dr. Blank, of the University Hospital? Does he not have a Coolidge tube, just like Dr. So and So, of the Chirurgical Clinic? And does he not use the same kind of plates as Dr. Whoze, of the Somewhere Roentgen Institute?

The medical profession must come to realize that roentgenology is not a photographic science, but that when certain means somewhat remotely allied to photography have been utilized to secure visualization of certain internal organs or parts, there is still absolutely essential the aid of an experienced medically-trained individual in order to secure reliable interpretation of the shadow findings.—*American Journal of Roentgenology*.

WHY NURSES GROW GREY

IN a recent letter home a young Canadian Lance-Corporal thus explains "Why Nurses Grow Grey."

"The next time a well-meaning stretcher bearer tries to interrupt my groans by his cheerful 'Buck up, old man, think of the swell nurses you'll have buzzing around you in the morning,' I shall either ignore him or present him with something which will be the direct cause of his being introduced to a bevy of these doctorettes.

"I'm not kicking or anything like that, in fact, I honestly think they mean well; but after a man has served his King and Country faithfully for twenty-one months and finally reached that haven of rest, the Canadian General Hospital, he naturally expects a little peace and quietness.

"But does he get it? No; most decidedly not. If the sister isn't taking your temperature, she's taking your shirt; if it's a clean shirt she will purloin a sheet; and it is while she is juggling this from under you that her eagle eye will alight on the cosy hollow that your manly form has made in the mattress. She groans and seeks the assistance of an accomplice. A tug-of-war follows, and your little nest is given place to an iceberg. Even in the night time, the sister will steal from her poky little desk, and if you so much as bat an eyelid she will pounce on you, thermometer in one hand and a glass of water and a pill in the other.

"I am probably the very first person to discover the real cause of premature greyness which accompanies the nursing profession. Most people imagine that a nurse ages in appearance through seeing so many terrible wounds; but that is not the case. She sizes up a case as a shingler would a roof. He would say so many shingles, while she estimates in yards of gauze and bandages.

"Now what really brings nurses to an early grave are the beds or cots. From sunny morn to dewy eve they tuck, stroke, massage and caress the beds. Their one ambition in life appears to be that of making a long row of beds look as though they contained no legs and bodies beneath the clothes; giving the heads and shoulders which rest on the pillows the appearance of belonging to people who have had their bodies run over by a steam roller.

"Just to show to what extent a nurse will go to get this desired effect in her ward, I might mention the case of a young fellow who used to have bed No. 11. He had a very bad leg which necessitated the installation of a contrivance to support the weight of the bedclothes. Struggle as they might, the sisters could not get that bed down to the level of ours. We all expected something would happen sooner or later, and sure enough one cold clear dawn we noticed No. 11 missing. At the solemn hour of midnight he had been either kidnapped or spirited away. It is now freely rumored around the ward that as a punishment for requiring a clothes support, No. 11 has been banished to England.

"Cruel world."—*Toronto Evening Telegram.*

Canadian Hospitals

THE EDITH CAVELL MEMORIAL

A NUMBER of ladies, including Dr. Stowe Gullen, as President, and Mrs. W. J. Wilkinson, as Chairman of the Finance Committee of the Ladies' Board of the Western Hospital, are seriously interesting themselves and the public generally in the proposed erection of the Edith Cavell Memorial, which will take the form of a Nurses' Home, to be erected in the grounds of Toronto Western Hospital.

"A year ago the Ladies' Board of the Toronto Western Hospital had under consideration the advisability of raising funds for the erection of a Nurses' Home on the grounds of the Western Hospital, as a memorial to Edith Cavell. This desire has now taken definite shape and a vigorous campaign will be launched in a few days.

"It may be well at once to set all doubts at rest regarding the object of the home. It is hoped and expected that enough money will be forthcoming to enable the Western Hospital Board to erect a building large enough for the needs of the nurses in training, and also for such other nurses as care to make use of it as a residence.

"Under any circumstance the idea of furnishing general accommodation for all nurses will not be lost sight of. It will, in this way, be truly a 'Nurses' Home.' It has been felt that this would be by far the most appropriate memorial that could be erected to the memory of the martyred nurse. This is in keeping with the wish of Miss Cavell's mother.

"One could hardly imagine a more suitable memorial than a home in which a nurse visiting Toronto, or a nurse resident in Toronto, requiring rest, or who might not be on duty, could find comfortable accommodation. To such an effort no one can find any objection. Indeed, one would expect that everyone would be eager to help.

"The site of the Western Hospital is very centrally located, and is favored by a very excellent street car service, so that

nurses can reach it readily from all parts of the city. In addition the new pavilions for the accommodation of patients are the most modern, sanitary, and best equipped in the Province. From this standpoint it would be an honor to have the Edith Cavell Nurses' Home connected with so deserving an institution.

"If the requisite amount is obtainable no efforts will be spared to make the home a credit to the city, and worthy of the memory of the noble woman whose name it is to bear. - It is the aim of the ladies to raise \$100,000; this would be about one dollar for each family in Toronto. There are many families in the city who could readily contribute liberally, and make up for those who are less able. The chief thing to fear is the feeling of indifference or unwillingness to assist on the part of some. When one recalls what nurses have done in this great war and the splendid life and tragic death of Edith Cavell, the person must be very lacking in the sense of appreciation, who will not contribute to such a memorial to the noblest of all nurses of all time."

OPENING OF THE SPADINA MILITARY HOSPITAL

"WE all cannot go to war. Some of us must remain at home and prosecute the important work that is necessary for the proper care and treatment of wounded Canadian heroes who are compelled to abandon their duties on the field of battle. Therefore, it is our duty to endeavor in every possible way, infinitesimal as our efforts may be, to afford them all the comfort and assistance that they demand by reason of the invaluable service rendered by the Canadian Expeditionary Forces on the field of battle. The wounded men for whom we must adequately provide have made supreme sacrifices for their country. They placed their lives in jeopardy so that we at home may continue to enjoy liberty and freedom. We cannot give them too great recognition."

The foregoing remarks, made on Wednesday afternoon, October 4th, by Sir James Lougheed, Chairman of the Dominion

Military Hospital Commission, sent a wave of enthusiasm and loyalty through a large and representative assemblage of citizens who were present at the formal opening of the Spadina Military Hospital, formerly the old Knox College. Sir Henry Pellatt, Chairman of the Toronto Division of the Dominion Military Hospitals Commission, occupied the chair. Among those on the platform were: Sir James Loughheed; his Honor the Lieut.-Governor Sir John S. Hendrie; Mr. W. K. George, Chairman of the Voluntary Aid Committee; his Worship Mayor Church; Mr. W. D. McPherson, M.P.P., Chairman of the Ontario Soldiers' Aid Commission; Lieut.-Col. Alexander Fraser, Major W. J. Munn, and Controller Cameron. Representatives were present from the various fraternal societies and other organizations which have given much time and labor to the cause of assisting in preparing comforts for returned wounded soldiers. The invocation was pronounced by Col. Canon Dixon of Trinity Church.

Sir John S. Hendrie, in formally declaring the building open for the reception of wounded and disabled soldiers, said that as a citizen he believed he voiced public sentiment in declaring that such institutions had not come any too quickly. He thought the Ottawa Government should bear the expense of such hospitals.

"Our sympathy goes out to those who have lost loved ones on the field of battle. Many of the men who have been through the tortures of war and disabled, I am sorry to say, will never again be able to return to the theatre of war. We gladly welcome our wounded heroes upon their return to Canada, and we are glad to be able to provide for them comfortably and render them every assistance possible. They are deserving of all that we can do for them."

Sir John urged that invalided soldiers who have no chance of going back to the trenches should be sent home to their relatives as soon as possible.

"The Federal and Provincial Governments should not err on the side of economy in providing the best accommodation possible for the care of the sick, disabled and wounded soldiers, who have attained noble achievements with the different contingents sent from Canada. This can only be done by more

funds, the generosity of the citizens and by having more hospitals of this character. The citizens have given money freely, and will continue to do so until the great struggle is brought to a close. The building is well equipped and our thanks go out to the various organizations, fraternal societies, the public school teachers and children, the clergymen, the Loyal Orange Association, the Ladies' Orange Benevolent Association, the Masonic Order and other kindred societies which have furnished the building. It is just an evidence of the loyalty of patriotic Toronto."

Following a brief outline of the relation of the Dominion Government to the work which is being accomplished by the Dominion Hospitals Commission, Sir James Loughheed said that while Canada had sent her forces to the war, it was equally important that those at home should co-operate with the Government in making adequate provision for the caring of the wounded soldiers invalided home. Military hospitals had been established throughout the Dominion. The policy of the Government and the Commission provides for the establishment of such institutions as required from time to time during the progress of the war and afterwards. These hospitals are being administered by the Government and the Hospitals Commission in conjunction with the many patriotic associations which have rendered invaluable aid.

"I have the greatest confidence in saying that when wounded and disabled soldiers are assigned to these hospitals they will find that the most adequate provision has been made for their comfort," continued Sir James. "The question of providing employment for returned soldiers is one of the most difficult problems that faces the Government and the people of the Dominion. It is a problem that will have to be solved by the Federal and Provincial Governments. It is a matter of profound satisfaction to say that there has been a most enthusiastic response on the part of the Ontario Government, and leading citizens of mercantile and financial circles have expressed a willingness to assume their full share and responsibility in working out this very complex question.

"The Commission has been glad to note that the business community of Ontario has done much to better the position of

the returned soldier, and there are many cases of soldiers who are able to work for their livelihood having been placed in better positions than they occupied before they enlisted. No Provincial Government in the Dominion has responded with the same enthusiasm as the Province of Ontario. It has rendered invaluable services in every line of patriotic endeavor, has given money freely and with a will, and sent more men than any other Province in the Dominion."

In tendering the thanks of the Dominion Hospitals Commission to the various organizations which so generously equipped the Spadina Military Hospital, Sir James Lougheed stated that he desired to especially thank the medical profession of Toronto for the splendid services they have rendered and gratuitously placed at the disposal of the different military hospitals and convalescent homes. Sir James added that the corporation of Toronto had demonstrated to the Dominion that she was ready to generously render financial assistance when called upon by the various funds and military units preparing to go overseas.

Sir James Lougheed further stated that over 6,000-wounded and disabled soldiers had already been distributed among the different military hospitals in the Dominion. Sir James also briefly touched upon the educational features of the work undertaken by the Commission in the matter of apprenticing soldiers who have recovered to different trades in order that they will be able to provide for themselves in the future instead of being a burden upon the country.

MOWAT HOSPITAL LEASED

MOWAT Memorial Hospital of Kingston has been leased by the Canadian Military Hospitals Commission from October 1 till three years after the war. Additions will be made to the buildings.

URGES CHANGES IN CANADIAN HOSPITALS

A COPY of the report of the investigation of Canadian hospitals in England by Col. Bruce, of Toronto, was recently handed to Surgeon-General Jones, Director of Canadian Medical Services. It is understood the report is a somewhat severe arraignment of the methods employed by the Canadian hospitals. Among other things, it is believed the report deprecates the fact that Canadians are not sent more to Canadian hospitals. The tabulation of statistics of the wounded is not satisfactory, V.A.D. hospitals unduly detaining wounded men fit for service.

Defenders of the system declare the doctors at the front are too busy trying to save lives, and have no time at the edge of the battlefield to write histories of patients to send back with them. These are sent later.

Apparently impartial critics state that a number of changes are desirable in the Canadian system, but that those in authority in the Canadian Medical Services are not to blame, but are merely following out the rules laid down. The fault lies with the Canadian system itself.

Among other recommendations, Colonel Bruce advises the taking over of the whole administration of Canadian Red Cross hospitals by the military, like the Ontario Hospital at Orpington. The report declares that the Red Cross administration is costing forty-eight cents per man a day, while that in the military hospitals is thirty-two to forty-three cents daily. He also states that there have been difficulties in administration between the Canadian military services and the Red Cross, and he advises closing the Buxton Springs Hospital for Rheumatism, saying that Canadians so afflicted are useless for service and had better be sent to Canada.

We understand that Col. Bruce recommends outside the report, the establishment in Canada of five hospitals of 1,000 beds each at five different places for our sick and wounded.

It is understood the Red Cross defence is that the slightly greater cost of Red Cross hospitals is more than compensated for by the comforts and accommodation given; that there is no friction with the military, and that the hospitals are running

most satisfactorily; that, furthermore, the Canadian Red Cross hospitals are not supported by the Government, but by private subscription, therefore Red Cross officials trust the Canadian public, whose consent is necessary to any change, and the Canadian supporters, in such event, must be compensated for any losses.

A DEACONESS HOSPITAL FOR TORONTO

THAT Toronto ought to have a Deaconess Hospital was the conviction voiced by the Rev. Dr. W. T. Perrin, President of the New England Deaconess Association, in addressing an open meeting of the Methodist Deaconess Aid Society in the National Training School the other day.

In the United States, Dr. Perrin said, the Methodist Episcopal Church has 870 licensed deaconesses, or, with probationers, about 1,000, compared with 70,000 sisters of charity in the Roman Catholic Church.

The deaconesses there have fifty-five homes, twenty-five hospitals, twelve training schools and five schools for general educational purposes.

The New England Deaconess Association has fifty-three deaconesses in its home in Boston, has a fresh-air home in Haverhill, a rest home for working girls, a training school in Boston, a training school in Concord, and a home for aged Methodist women in Concord.

But of all phases of deaconess work, Dr. Perrin spoke particularly of the hospitals. The one started in Boston in 1896 in a residence, has secured the support of the best physicians of that city, and now has seventy beds, while one in Concord has twenty beds. Last year these two hospitals cared for 1,462 patients, and gave \$8,467 worth of free service. It was interesting to hear that 184 of these patients were natives of Canada.

Following the description of the work in Boston, Dr. Perrin made some strong representations in favor of starting a Deaconess Hospital in Toronto. He spoke of the increasing demand

for hospital service everywhere, this being partly due to the realization that the hospital is the best place for the average person to be sick in. As apartment houses multiply this realization spreads.

Dr. Perrin went on to the opportunity for evangelization and the possibility of making the hospital a centre from which to send out district nurses, and finally suggested that the estate of the late Mrs. Massey-Treble on Jarvis Street would make an ideal home for such a work, and moreover it had been left in such a way that it could be had for such a purpose if desired.

While Mr. Chester Massey had expressed himself as being quite in sympathy with such a movement, the speaker felt that the initiative should come from the outside, and that a peculiar responsibility rested on the people of Toronto.

Such a Hospital would pay its own way, Dr. Perrin said, and it would be possible to do much work free, as well.

"Many people," he declared, "if you render the best possible service, will prefer your Hospital to any other, and pay your top prices for what many a person of means desires more than anything else, the Christian sympathy of such an institution."

DOUGLAS S. ROBERTSON.

AMONG those from Canada who attended the meeting of the American Hospital Association in Philadelphia, a few weeks ago, were Mr. Webster, of the Royal Victoria Hospital, Montreal; Mr. Parke, of the Montreal General Hospital; Dr. Robertson, of the Ottawa General Hospital; Dr. Clarke, of the Toronto General Hospital; Miss Florence Potts, Superintendent of Nurses at the Sick Children's Hospital, Toronto; Mr. John Ross Robertson, Chairman of the Board of Trustees at the Sick Children's Hospital, Toronto; Dr. Whyte, of the Isolation Hospital, Toronto; Miss Gray, of Winnipeg General Hospital; and Dr. Walker, of St. John, N.B.

War Hospitals

HISTORIC PLACE FOR MAIMED—CLARENCE HOUSE A HOSPITAL

ERE this appears in print a little contingent of Canada's sons, non-coms, and privates, sick and wounded, some bereft of limbs in the war, and waiting the adjustment of artificial arms or legs will be comfortably lodged in spacious old Clarence House, latest addition to the Canadian Hospitals.

Walking up a leafy lane through the charming suburb of Roehampton on the great city's outskirts, one enters a gate wherefrom a gravelled path leads to a solidly-built mansion. Under the pillared portico at its front door royalty has often alighted from a coach-and-four, or, tossing the bridle to a groom, slipped from the saddle of a horse. For here, in days long gone by, lived Mrs. Jordan, the celebrated English beauty and actress, morganatic wife of William IV.

'Tis said that still, in the dead of night, the spirit of its fair, former mistress sometimes appears, gliding about the hallways and the lofty reception rooms of the house wherein she once reigned. Her wraith, they say, is arrayed in a gray dress, and those perfect features which captivated a King of England still smile serenely.

However, when the writer called a few days ago, none of the Canadian V.A.D.'s had seen the ghost. Sound asleep are these young ladies at such spooky hours, tired out with their work. Indeed, Miss Lewis and her staff have had a strenuous time getting the Hospital ready for the reception of their wounded countrymen.

Situated in a finely-wooded park of several acres, and surrounded by the open spaces of other estates, Clarence House might well be right in the country, so fresh and healthful is the air. High ceilings and many windows make lighting and ventilation easy, and the various large rooms are rapidly being transformed into pleasant wards. Indeed, many a wounded

Canadian will say that he has never been so comfortably housed as in this suburban home.

A Toronto boy, Pte. Weddington, was the first orderly to arrive, and, oddly enough, it devolved upon him to repair the fire-escape already on the building—a fire-escape invented by his own father.

Clarence House is auxiliary to the King's Canadian Red Cross Hospital at Bushey Park. Opening with fifty patients the Hospital will shortly be ready to accommodate seventy-five or even one hundred. The staff of eleven comes mostly from Ottawa, Miss Winnifred Lewis being in charge, with Mrs. H. Pinhey looking after the housekeeping arrangements, and Miss H. Hughson, honorary secretary. Of V.A.D.'s there are: Miss June Allen, Toronto, and the Misses Mildred Goodeve, Marjorie Jones, Lillian Monk and Jessie McLachin (chauffeur), all of Ottawa, Ont.

Personals

DR. F. A. AYLESWORTH, who practiced for some years at Roseneath, sailed the first week of October from Boston for London. Dr. Aylesworth expects to be identified with the Eye Department in the Howard University Base Hospital Unit.

Major (Dr.) Munn, who was recently appointed Chief Medical Director of the new Military Hospitals Unit, took up his new duties a few weeks ago and his office is at 1 Queen's Park, Toronto, the old Riordan residence.

Captain (Dr.) Ogden is now in charge of the Central Hospital on College Street, Toronto, with Capt. Ley in charge of the new Spadina Hospital. The latter hospital will be kept entirely for men who do not require constant medical treatment.

Command of the Bramshott Hospital has been given to Col. R. C. McLeod, of the camp of the St. Francois Xavier unit which has been increased to the strength of a general hospital.

Dr. W. S. Verrall, orthopedic surgeon, of Vancouver, B.C., has been appointed to succeed the late Dr. B. E. McKenzie as Superintendent of the Toronto Orthopedic Hospital. Doctor Verrall was a former member of the staff of the Toronto Orthopedic Hospital and an associate of Doctor McKenzie in his private practice. The hospital work will, of course, be carried on as usual.

Book Reviews

Physics and Chemistry for Nurses. By AMY ELIZABETH POPE. Illustrated. New York and London: G. P. Putnam's Sons. 1916.

With the marked advance in nursing educational standards comes the necessity for suitable text-books. We are pleased to recommend this little work on physics and chemistry, because of its practical character. The subjects discussed are easily grasped by the nurse of average intelligence. The chapters on cooking, cleaning and disinfection give examples of the eminent practicality of the work. Hundreds of interesting experiments are described.

The book should meet with a kindly reception from nurses in training as well as from graduates.

Practical Points in Nursing. By EMILY M. A. STONEY, late Superintendent of Training School for Nurses, Carney Hospital, Boston, Mass. Fifth edition, revised by Lucy C. Catlin, R.N., of the Youngstown Hospital, Ohio. 12mo of 511 pages, containing 102 illustrations. Philadelphia and London: W. B. Saunders Company. 1916. Cloth, \$1.75 net.

The publishers of this book, now in its fifth edition, have very wisely had a nurse revise on this occasion. Since one of the strong points of the book is that it gives very definite directions for actual nursing, it is fitting that they should come from a nurse.

The book is written for nurses in private practice and is particularly valuable for them, as it contains in a comparatively small space much ready information on numerous subjects, commencing with the nurse herself, then the sick room, patient, appliances, food and different treatments. It cannot be recom-

mended, however, as a text for use in a training school or as a book of reference.

The chapter on Nervous Diseases, added in this edition, is somewhat elementary, but nevertheless will be found helpful.

This book has a definite field of usefulness. It will be found valuable by the nurse who has been engaged in private practice for some years, or by the recent graduate less familiar with the conditions as they exist in the home.

E. G. F.

Burdett's Hospitals and Charities, 1916. Being the year book of philanthropy and the hospital annual. Containing a review of the position and requirements, and chapters on the management, revenue and cost of the charities. An exhaustive record of hospital work for the year. The most useful and reliable guide to British, American and Colonial hospitals and asylums, medical schools and colleges, nursing and convalescent institutions, consumption sanatoria, religious and benevolent institutions and dispensaries. By SIR HENRY BURDETT, K.C.B., K.C.V.O. 27th year. London: The Scientific Press, Limited, 28 Southampton Street, Strand, W.C.

Sir Henry Burdett, in his foreword, draws attention to the approaching vacancy which must in the ordinary course of events occur in the editorship of this annual—Sir Henry being now nearly three score and ten and having championed the voluntary hospital system for half a century.

He states that if the book is to continue, it is essential that some competent and authoritative person with knowledge and a keen interest in the voluntary system should come forward and offer his services as a successor to Sir Henry in the editorship.

The Annual, as usual, contains a statement of the volume of charity; a report on the King's fund and the League of Mercy; on the nursing department, hospital Saturday and Sunday, Missions, Orphanages, Deaf, Dumb and Blind Asylums, and convalescent institutions.

Chapters are devoted to hospital construction, hospital finance and hospital conditions in United States, Canada, Australasia and India.

The customary directory of institutions occupies the major part of the book.

Every Canadian hospital should have a copy in its library.

Radiography, X-Ray Therapeutics and Radium Therapy. By ROBERT KNOX, M.D., M.R.C.S., L.R.C.P. With 64 plates and 246 illustrations in the text, and a frontispiece in color. London: A. & C. Black, Limited. 1915.

This is a practical work, giving particular attention to the practical working of apparatus, hence of great value to the beginner in X-ray work. A goodly number of pathological diagrams have been incorporated in the text.

Of special interest are chapters on the localization of foreign bodies, radiography of normal bones and joints, diseases of bones and joints, examination of the thorax, alimentary system and urinary tract.

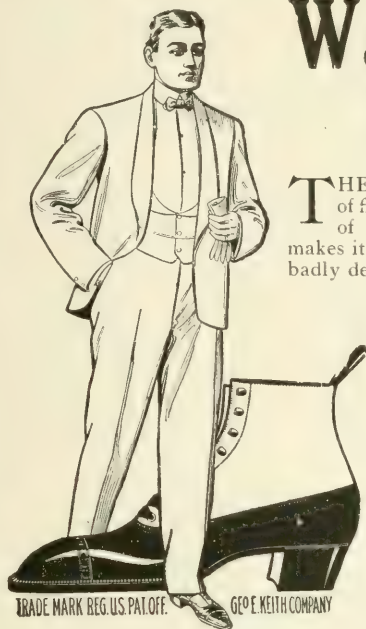
The treatment of diseases of the skin, lymph glands, rodent ulcers, sarcomata, carcinomata, enlargement of the prostate, exophthalmic goitre, uterine fibromata and of diseases of the blood, lungs and mediastinum is given.

Mr. C. E. S. Phillips writes the section on radium therapy.

Dr. Knox has made a fine contribution to this new and engrossing subject.

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NEW HOSPITAL APPLIANCES, ETC.

Antiphlogistine in Foreign Lands

"I TAKE pleasure in informing you that both in the garrison infirmaries where I was stationed, as well as when I was with the troops in the interior, I have had every reason to congratulate myself with respect to the good effects derived from Antiphlogistine. I regret that my time is so occupied that I am unable to jot down a few succinct abbreviations, but I can assure you that I have obtained excellent results in cases of contusions and sprains, as well as in certain ulcerations and wounds affecting the lower limbs during the marches. To sum up—I have obtained good results in every case in which a permanent warm dressing was indicated."

DR. CHAMPNOIS,

First Assistant Physician,

First Battalion Zouaves,

Charon Garrison, Algiers.

The Physician's Duty

PHYSICIANS are becoming more and more impressed with the value of prophylactic measures. Therefore to instruct patients of the gentler sex in hygienic and sanitary principles and procedures is both a duty and a privilege.

It is a fact, often not entirely appreciated, even by physicians, that the vaginal douche, properly employed, should be used frequently even in the absence of any abnormal condition. Despite the opinions sometimes expressed that frequent douching is not advisable, that the natural secretions being sufficiently germicidal should be allowed to remain, etc., it is a matter of common knowledge and experience among women of any degree of refinement that proper toilet of the vaginal tract is as valuable, necessary and indispensable as the use of the toothbrush.

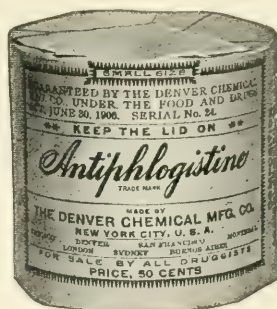
This being true of women whose genital tract is in a normal and healthy condition, it applies with augmented force to the vast proportion of cases in which there is some abnormal condition present, such as excessive mucous secretions, leucorrhea, vaginitis, endocervicitis, endometritis, congestion, irritation, etc.

It is indeed a matter of common and daily experience that women who are nervous, irritable, easily worried, cross, peevish, moody, etc., are often greatly benefited by the use of warm or hot vaginal douches, properly employed by means of a suitable apparatus or syringe.

Cleanliness of the genital tract is for women not only a valuable sanitary and hygienic measure, but also in many instances an absolute necessity, in order to prevent physical irritation or discomfort, as well as mental unrest.

Pneumonia, Pleurisy, Bronchitis, Quinsy, Laryngitis, Etc.

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These plates have been made at Toronto for the last couple of years, and are identical in quality with the Seed X-Ray Plate, made at Rochester, N.Y., which has attracted so much favorable attention at the various conventions and association meetings across the line. Our readers are referred to the advertisement on page vi.

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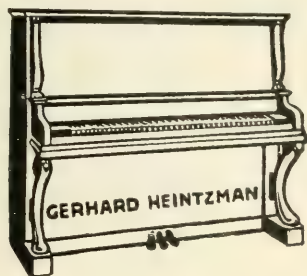
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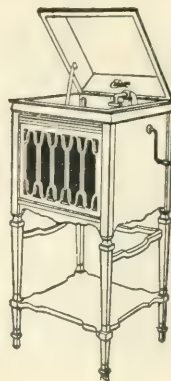
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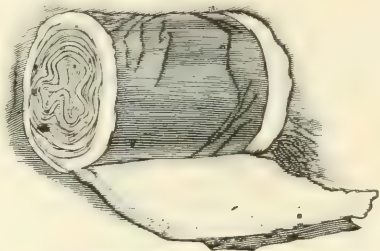
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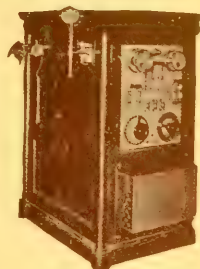
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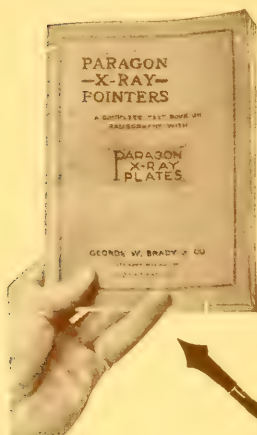
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THE HOSPITAL WORLD

Vol. X (XXI)

Toronto, December, 1916

No. 6

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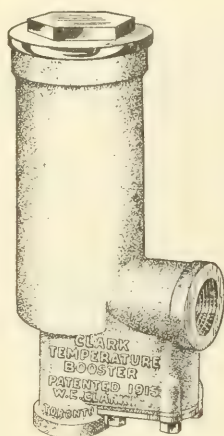
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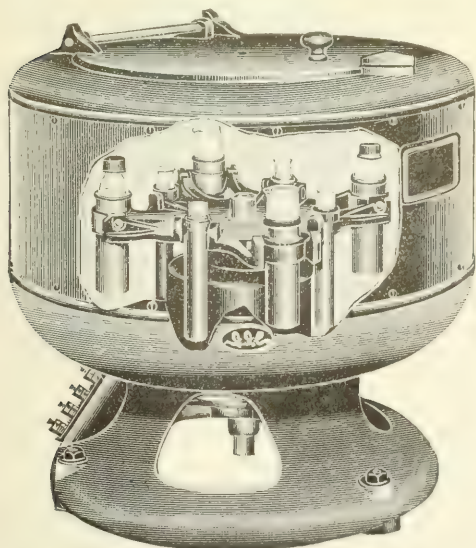
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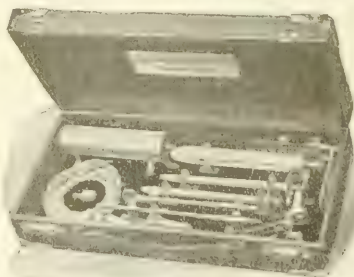
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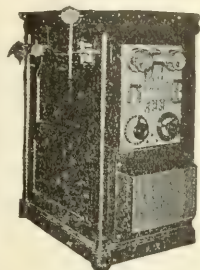
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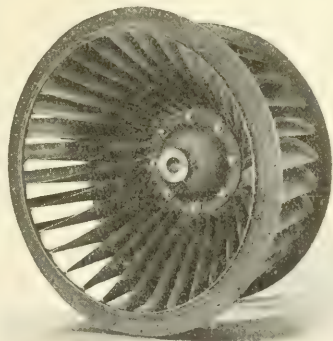
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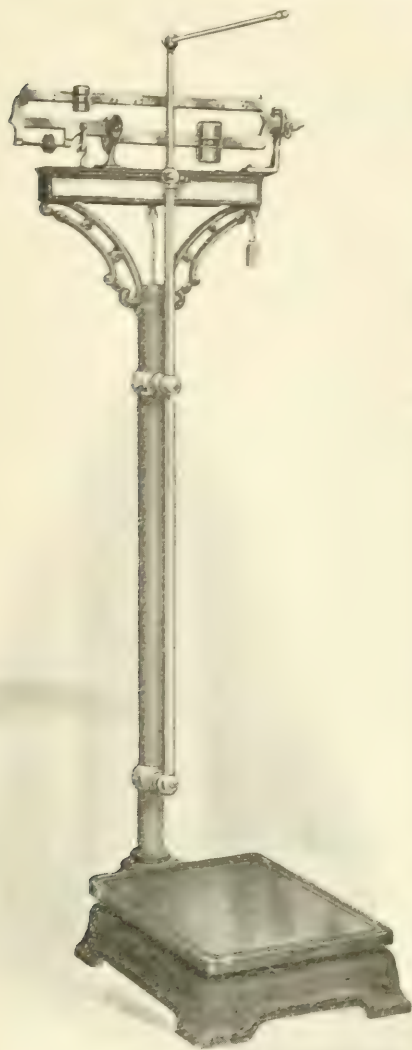
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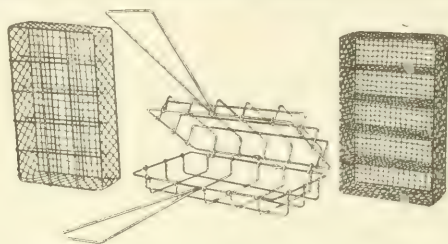
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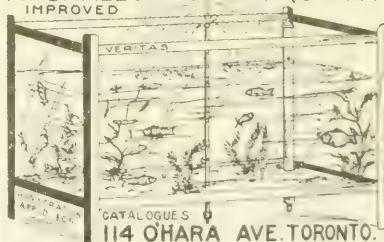
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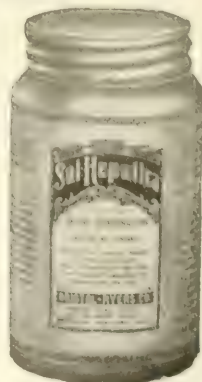
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TORONTO, DECEMBER, 1916

No. 6

Editorials

THE CANADIAN HOSPITAL SITUATION OVERSEAS

JUDGING from Colonel Herbert Bruce's report, recently filed with the Minister of Militia, a *resume* of which will be found in this issue, there are many

reasons why the different Hospital Units sent from Canada and now stationed in England, France, Egypt and Greece are in immediate need of re-organization. It is quite evident that there has been gross mismanagement in many quarters, and our Department of Militia and Defence did well in sending so representative a member of the profession in Canada to look into hospital affairs in the Old Country and, in conjunction with a duly appointed Board, make recommendations that would result in such matters being put on a proper basis.

The report is exceedingly thorough and comprehensive and will have a most beneficial effect, *providing* meddling politicians be told that it is a case of "Hands off."

Artists tell us of the great importance of true perspective, so in discussing any absorbing question of the day, everything depends on the viewpoint, the correctness of which can only be judged by having, for its pivotal point, incontestable fact. Unfortunately, hastily formed opinions and rushing into the lay press, and commands flying across the cable wires by partially informed ladies, have caused comment and discussion of the report, which to the minutest detail is based on verified fact.

Women have taken a beautiful helpful place in this world's war—all hats off to them!—but we implore them to stay on that pedestal where they have so worthily climbed, revered by all, and not come down to meddle in what is not their business. Knowl-

edge is power; but a little (executive) knowledge is a dangerous thing.

Who is there who does not proudly claim allegiance to Great Britain, and who dares not to honor the Grand Old Flag that has so long and so nobly "braved the battle and the breeze"? We know of none. Then why even refer to Imperialism, or hint at the lack of that spirit in those whose views slightly differ and prefer that their boys convalesce in a Canadian hospital, under a Canadian surgeon, with a Canadian nurse to hasten them back to health. Is it not the most natural thing in the world for those who have given their all to prefer that their husbands, sons or sweethearts occupy a bed alongside of a pal from the same regiment or a fellow townsman from the same city to cheer him on. By all means, we say, have Canadians sent, as soon as practicable, from the Field Hospital nearest where they were wounded, to a Base Hospital sent and equipped by Canada, "Daughter she may be in her mother's house, but (let us not forget) mistress in her own." Unless this is done the Canadian Army Medical Service is not fulfilling the purposes for which it was originally designed, viz., the attendance on *Canadian* sick and wounded.

As the report says, there should be proper and careful use of the money sent by Canadians, often at a sacrifice undreamed of by the English people, who seem to think always of Canada as a land "flowing with milk and honey"—"Please send on the combs;

England will graciously accept them and enjoy the honey."

The heart of young Canada is not in her gifts, but as the days go by even greater sacrifice may be necessary, so every care should be used in expending even the pennies.

There are many points in the report to which we would like to refer at length, but space does not permit. We fear that it is all too true that many officers have been given commissions who have been worse than failures in private practice, and here is where politics is the curse of any nation. We are sorry to learn that there are medical officers who have been drug addicts and alcoholics. Why such appointments? Such men are useless as officers and most detrimental to their unit. The subject of promotion has also caused a great deal of trouble during the past two years and must be put to rights. In many cases there has been no relationship whatever between the length of service and the ability of the officer, on the one hand, and his rank on the other. We could name many instances of medical officers who have been promoted, and who on arriving Overseas compare most unfavorably with their juniors. Why, we ask, is it a well-known fact that our younger men, who do the nerve-racking work at our Field Dressing Stations, seldom or never receive promotion, and those who remain at the Base are immediately promoted to the rank of major or lieutenant-colonel? What excuse could there be for the employment of our best known specialists on routine work;

our surgeons, for example, employed in the treatment of dysentery in the Balkans? It would also appear as if there is no doubt whatever that the physical examination of our recruits at the time of enlistment has been exceedingly bad, and that the Government has been put in for the outlay of many thousands of dollars through a regular army of men having to be returned to Canada as physically unfit, the records showing that the Canadian Government expends at least \$3,000 on every enlisted soldier by the time he completes his training. Dealing with the subject of operations, Colonel Bruce denounces as utterly useless many operations done, apparently by a lot of younger surgeons, and which produce no increased military efficiency. "War," he states, "is not a post-graduate school, where surgery or any other private hobby may be cultivated by individuals at the expense of the country." What is the reason for all this? It is all the result of *Governmental incompetence, fear and favoritism*.

The wretched state of affairs as shown must be handled at once without fear, but with courage and determination. Will this be done, or are those incompetents and moral weaklings to continue in office? Promotion must be by merit and merit alone. The mess must be cleared up forthwith.

The medical profession throughout Canada is proud of the ability of our confrere in making such a report, of his courage in telling the unvarnished truth (knowing it might cause personal criticism),

and for his patriotism in standing to his guns, like the true Canadian he is.

The war has called some to honor, many to sacrifice, and more to service. It is easy to be an arm-chair critic in relation to the management of the war, the care of its wounded, and many subjects allied to the world's saddest hour. The temptation for riding roughshod with a "hobby" for a mount seems very alluring, especially to a certain type of woman. The great Kitchener left a new commandment, ere he slipped off into the Great Unknown Adventure: "Silence." Was that his legacy? We wonder?

W. A. Y.

November the second.

Original Contributions

LITTLE JOURNEYS

BY DR. J. N. E. BROWN.

Superintendent, Henry Ford Hospital, Detroit, Mich.

THE CINCINNATI GENERAL HOSPITAL.

THIS hospital is located some three miles from the centre of the city of Cincinnati. It occupies a commanding position, there being fine vistas every way one looks.

The Cincinnati General Hospital is a city-owned institution, managed by a board of five commissioners, one of them being the mayor. The leading spirit of the institution is Dr. C. R. Holmes. Dr. Holmes is dean of the medical college which is affiliated with the hospital, and provision is made in all the departments for the teaching of students. A large amphitheatre is provided in both the surgical and pathological units for didactic work. The laboratories in the pathological building are well provided with working space for the students. A separate gowning room is provided for them in the operating building. Mrs. Holmes is undertaking to provide a buffet for them.

During the fifteen years of arduous campaigning by Dr. Holmes, he has had much opposition—the indifference of the public and the opposition of certain politicians. His policy has been to educate the common people—the laboring class, which he has won over almost to a man. He has addressed representative labor organizations and fraternal organizations, and even addressed meetings on the street corners. He pointed out to the poorer and middle class of people who looked to the old hospital for care—tumble down, ramshackle, infested with rats and vermin—what they had a right to expect as citizens and taxpayers.

The hospital is open to visitors daily—not to the general wards alone, but also to the contagious wards. The relatives

and other visitors wear gowns, wash and take the same precaution as the doctors and nurses take.

The educative value of this procedure was well illustrated by a story Dr. Holmes tells: A certain Mrs. Flannigan, whose child had recovered and gone home, called at a neighbor's house where a child lay sick with the scarlet fever. Observing that the family doctor in visiting the child did not put on a gown, remarked to the mother of the sick child, "Shure, Mrs. O'Flaherty that doctor nades educatin'."

The institution is built on the corridor pavilion plan. The pavilions, as a rule, run north and south and are seventy-five feet apart. The head house is at the north end. At the end of the headhouse is the corridor which consists of open arches, beneath this corridor are the connecting tunnels, and the top of the tunnel is available for getting patients out of doors. The pavilions are arranged in two rows; and between these two rows are situated the receiving department, the kitchen and the operating building. These service buildings are sufficient to meet the needs of at least 1,400 patients. The administration building is in a line with the central pavilions and faces the entrance to the hospital. The pavilions are three stories in height with a basement and a flat roof.

These roof wards are open to the sky, and are quite unique. They are surrounded by a wall about ten feet high with a coping. This surrounding wall is well supplied with windows which are covered with glass and have protective bars.

It is proposed to stretch a canvas from the top of the coping on one side to the coping on the other side, thus giving shelter from the sun and rain. This open ward is supplied with the usual accessory rooms, kitchen, toilet, and utility rooms, etc. A water pipe conveniently located permits the flushing of the roof in summer, which not only cleanses the surface but also cools it. A steam outlet is also provided which enables them to melt the snow which collects on the roof in winter, thus keeping the floor available for the use of the patients.

As the hospital proper has only been occupied for a short time, the roof wards have not come into general use as yet.

Dr. Holmes has spent some fifteen years in the careful study of hospitals, not only in America, but also in Europe. He has

taken particular pains to work out the ward unit—in fact he had given more attention to this point than any one whom the writer has known.

The Cincinnati ward unit, as before stated, runs north and south. It consists of the ward proper and the subsidiary rooms located on each side of the corridor. The corridor is 67 feet long and 8 feet wide. The ward is 90 feet long and 30 feet wide and 13 feet high. Upon one side of the corridor, commencing at the entrance is a treatment room, in which blood and urine are examined, four small wards (one with two beds and the others with one bed each) a closet for warming blankets, a linen supply room with a drying room off it, a nurses' toilet room, and a housekeeper's sink room. On the other side of the corridor are a kitchen, dining room for convalescent patients (opening into the kitchen as well as into the corridor), a bathroom and sink room.

Between the kitchen and the general corridor connecting the pavilions are an elevator and a stairway, and between these two latter and the corridor of the unit is a fresh air cutoff—being a space about 7 x 19 feet. The food trucks from the main kitchen are wheeled from the elevator into this fresh air cutoff, and the food containers with the food are set in an opening in the wall which connects with the kitchen. This cutoff opens by a door (on the ground floor) into the connecting corridor, by a door into the ward corridor and by a window into a ventilating shaft which runs to the top of the building.

This arrangement precludes the air from getting from one ward unit to another.

The ward itself contains twenty-four beds which are set well away from the walls and windows. There is a nurse's table directly in the centre of the ward. The head nurse's station is at the head of the ward, and is separated from the corridor by a glass partition, which enables her to have command of the corridor as well as the ward. Different colored lights at her signal box enable her to tell whether a patient is calling from one of the small wards or the large ward. There is a third signal which comes from the bathroom. It enables the bath nurse to signal if she is having any trouble with a patient.

The headhouse extends out several feet on each side of

the ward. Just at the junction, on either side, are two small rooms. The room on one side is called the nurse's room—here she makes poultices, etc., this room opens into the sinkroom as well as into the ward. It has two windows, one looks southward and the other westward. These two windows afford an air cutoff. The corresponding corner on the opposite side is a physicians' lavatory, not enclosed; and from it a door leads into the patients' toilet. The patients' bathroom which lies next, has two baths. Each sinkroom off each ward has a separate clothes chute. The chutes adjoin one another and terminate in a common receiving room in the basement. In each sinkroom is an enemata stack in which specimens of urine and fecal matter may be placed until taken to the laboratory. An upward draft is provided to prevent any odor from getting into the sinkroom. The whole south end is occupied by a solarium which is fourteen feet nine inches in width. In one corner next the ward, is a sinkroom, and in the corresponding room opposite is a toilet. The partition between the solarium and the ward is largely of glass, so that the ward is not darkened by the solarium. All the floors are of tile. The windows extend to the ceiling and to within about thirty inches of the floor. The transoms open outward and are provided with aprons on each side to prevent side drafts.

The Receiving Department.

The receiving department is immediately behind the administration building. In front of it is a spacious ambulance entrance, with double doors on each side, which in inclement weather may be closed. The front of the ambulance entrance is connected by a corridor with the receiving unit proper. Here is a capacious waiting room with seats to accommodate twenty or thirty people of each sex. In the centre of the large, common room is an office with desks on three sides where data regarding patients is noted down.

It may be said, in parenthesis, that to this department patients who have been discharged from the hospital come for subsequent advice and treatment. Each half of this floor is like the other. Each side of these waiting halls where patients are seated is a suite of three rooms connected with one another

by sub-corridors, two of these rooms are examination rooms, and the third a capacious bathroom.

Here the patients are cleaned thoroughly after which they are given hospital clothing—their own clothing being sent to the basement of this unit where it is fumigated, mended, pressed, and placed on hangers. Each suit is placed in a large paper bag, on the outside of which is a list of the contents. When the patient is ready to be discharged, he is brought to this same receiving unit back of which are numerous cubicles where the patients take off their hospital clothing and habiliterate themselves in their street costumes.

In the receiving department are two wards, one for males and one for females, each of which contains five patients, for the accommodation of all patients who come to the hospital for admission after 9 p.m. This prevents disturbing the patients in the general pavilions after they have gone asleep.

In the basement of this department are large rooms for the special treatment of heat stroke, and for patients who have been poisoned. We noted a cabinet with antidotes for the latter sort of case.

The following bottles are kept in the poison cabinet in the receiving ward: Lime water, magnesium sulphate, 50% solution; ammonia water; potassium permanganate in solution each drachm containing 1.25 grains; oxalic acid; an arsenic antidote consisting of two bottles, No. 1 containing 32 ounces of magnesium oxide, and the second containing 16 ounces of the solution of iron sulphate. The directions for administering are that the magnesium oxide is to be well shaken and gradually added to the iron sulphate, the entire 48 ounces being administered as an antidote. There are also bottles containing oil of turpentine; camphorated oil in 20% solution; alcohol, 95%; sweet oil; glycerine; castor oil; aromatic spirits of ammonia; whiskey; sherry wine.

There are also some small bottles filled with precipitated chalk; tannic acid; ground mustard; sodium bicarbonate. About one dozen fresh eggs are always kept on hand in this cabinet.

Between these two wards mentioned above are four rooms, two on each side of the short corridor, connecting with the

back entrance. The two on the right side are devoted to sterilization and operating. The two on the left side are an attendant's room and a store room. This suite constitutes a surgical casualty department.

The stay of patients here is only for a few hours at night; therefore, no kitchen equipment has been provided. Milk and liquid nourishment are, however, available.

Social service is conducted in this receiving department.

Contagious Department.

One part of the grounds is set aside for a group of contagious buildings, somewhat remote from the other buildings. One unit is set aside for each of the chief contagious diseases. In another building there are four units for the four minor contagious diseases. Each unit being a small hospital within itself. A separate building is used for the detention of smallpox cases before their removal to the smallpox hospital. It contains four rooms, a room for the nurse, a kitchen, toilet and bath and a sink room.

Pathological Building.

In the pathological building, on the basement floor, there are refrigerators for the care of bodies; four rooms, one for the coroner, one for the undertaker, one for autopsies, and a chapel where funeral services and religious services on Sundays are held. On the first floor is the Director's office, reading-room and library. The second, third and fourth floors are taken up by laboratories: Physiological chemistry, bacteriology, serology; photographic rooms and rooms for experimental research. There is a large amphitheatre at the north end of the building; also a museum which is well stocked with specimens. The fifth floor is devoted to the care of animals for experimental work. The infected ones are kept away from the non-infected. A sterilizing and animal operating room are also provided.

The Laundry and Power Plant.

The laundry is an ample place fitted up with the latest machinery. Rest rooms are provided. The power plant is an enormous one, being large enough for the addition of future

installations. Gas is used as fuel instead of coal; the wages of many employees is thus saved, and gas is much cleaner than coal. The general refrigerating machinery with a capacity of twenty-five tons per day, is housed in the service building. The small refrigerators of the wards are filled with ice which is carried to them. We noted in another building a small separate refrigerating plant, the refrigerative agent being sulphur dioxide.

The Nurses' Home.

The Nurses' Home is a fine building, located at the right of the front of the lot. It is near the street, but is not fenced in. In the basement are rooms for the servants who work in the home; kitchens, and a laundry. On the main floor are the dining rooms, parlor and reading-rooms. Remembering the penchant of nurses for sweets, a small candy kitchen is provided for them. There are demonstration rooms and laboratory rooms where simple chemistry and analysis of body fluids are taught. The upper floors are occupied by sleeping rooms. There are ample bath and toilet rooms, also an infirmary where nurses are taken who are too ill to work, and not ill enough to be taken into the hospital. There is also a roof garden which is covered over in part by a roof and part by canvas, where nurses may go about in their kimono and enjoy themselves in a free and easy way. This may also be used as a sleeping porch.

War Hospitals

THE CANADIAN ARMY MEDICAL SERVICE UNDER THE SEARCHLIGHT

A REPORT on the Canadian Army Medical Service, presented a few weeks ago to the Minister of Militia by Col. Herbert A. Bruce, of Toronto, whose official title is Special Inspector-General Medical Services, Canadian Expeditionary Force, is, it is safe to say, one of the frankest indictments of a Government service ever received by the responsible Minister. The report is dated September 20th, 1916, and is the result of investigations carried on subsequent to July 31st, 1916, so that it is distinctly up to date.

The report is divided under twenty-three headings. Each one of them is an indictment, and judging from the headings, as printed at end of this article, is intended to be such.

In introducing his report, Dr. Bruce announces that all of its criticisms and recommendations are not merely his alone, but have been endorsed by each member of the committee appointed by the Minister, at Dr. Bruce's request, to assist in the work.

The committee consisted of Col. F. A. Reid, Director of Recruiting and Organization; Col. Wallace Scott, Lieut.-Col. Walter McKeown, Lieut.-Col. F. W. E. Wilson, Capt. Chas. Hunter.

Dr. Bruce absolved the medical and nursing staffs from blame, as he found doctors and nurses discharging their duties in a most self-sacrificing and exemplary manner. Many of the medical staff are, however, placed in positions where their special training is not being used to the best advantage. The responsibility for this waste must be laid at the door of the D.M.S., who, says Dr. Bruce, in many cases appears to have

ignored special qualifications altogether and distributed the personnel in a most haphazard way.

The question of segregation of Canadian wounded which has recently been receiving notoriety, largely through the activity of Canadian ladies in England in writing to the papers there, is very fully dealt with by Dr. Bruce. Dr. Bruce is emphatically in favor of segregation. How the Canadian wounded and ill are at present scattered about is evident from the following statement of facts:

"On August 18th of this year we had in England 12,018 cases, of whom 6,747 were overseas sick and wounded, requiring active treatment. Of these, 5,135 were being taken care of in British hospitals, and only 1,612 in Canadian hospitals. The balance of these cases had arisen locally or were convalescents. The 5,135 Canadian patients were located in 100 British hospitals, widely scattered over England, Scotland, Wales and Ireland."

Dr. Bruce sees no difficulty in segregating Canadians. The British service is able to send casualties from the Royal Flying Corps to a Royal Flying Corps Hospital, and even go so far as to send wounded Somersetshires to Bristol, so as to be near their friends. There should, therefore, be no difficulty in keeping Canadians together.

He reports that he found, both in England and France, Canadian soldiers begging to be taken to Canadian hospitals. He found also Canadian medical officers constantly complaining that although they had sacrificed their practices at home with the object of helping to take care of our soldiers overseas, yet they rarely had an opportunity of treating a Canadian patient. A map accompanying the report shows how the 100 hospitals in which Canadians are located, are scattered all over the British Isles. The cost of transport in itself is considerable. If the 5,135 Canadian patients in hospital on August 16th had been taken care of by a concentration of hospitals in the Shorncliffe area there would have been a saving in transport alone of \$11,348.35.

In addition Dr. Bruce found some instances when the treatment received by Canadians in British hospitals has not always

been as satisfactory as it might be, and further that nobody in those hospitals seems interested in the discharge of patients when they are fit to be sent to a convalescent home.

Special reports are given to show how this works out. In seven British hospitals in the London area and in Aberdeen, Scotland, special inspectors found 248 Canadian patients. It was found that 116 of these should have been sent to convalescent hospitals, 52 others should have been discharged as permanently unfit for further service, and 13 suffering from contagious diseases should have been elsewhere, that is to say, out of 248 Canadian patients, 171 should not have been in these hospitals at all. This illustration is thought to be typical.

Dr. Bruce says that his experience with sick people leads him to the conclusion that when they are ill they prefer to be among relatives and friends. Further he says, "I take the position very strongly that as it is our duty to see that our boys who go to the front are cared for in the best possible manner when they are wounded and sick, and as we shall ultimately be responsible for their pensions, it is imperative that we should ensure that they are under the immediate supervision of our own medical service."

As to how the present policy of distributing Canadian soldiers arose, Dr. Bruce gives the following particulars:

On June 16th, 1915, Colonel Hodgetts wrote to Surgeon-General Carlton Jones, suggesting that as special arrangements had been made for sending wounded Canadians to the Queen's Canadian Hospital, Beechborough, could not similar arrangements be made in regard to the Duchess of Connaught's Hospital at Cliveden. Accordingly on June 18th the D.M.S. wrote to the War Office requesting that the Cliveden Hospital should "as far as possible be reserved for sick and wounded Canadians from overseas." The War Office acceded to this request, and gave instructions that Canadian soldiers (other than officers) should be sent to one or other of the two hospitals mentioned above. Later representations appear to have been made to the D.M.S. that for Imperial considerations it was advisable to spread the Canadians throughout the British Isles. On December 17th the D.M.S. replied, expressing the opinion that "it is

conducive to the patients' well-being and comfort to be under our own administrative control."

"As a consequence of this arrangement many more Canadians found their way to these two hospitals, yet in spite of this we find that the D.M.S. on February 2nd, 1916, wrote to the War Office to ask that these instructions be amended, and in a further communication dated March 25th, 1916, stated 'that it is not now considered necessary from a Canadian point of view to make any special arrangements at Southampton for the collection of Canadian patients.' No reason is assigned for this complete change of attitude."

In this connection Dr. Bruce points out that Canada has maintained at Saloniki, where there is not a single Canadian soldier, three hospital units with a total bed capacity of 320 patients. And in France we have on an average 2,000 beds in excess of the number of Canadian patients.

Dr. Bruce also strongly complains about the lack of policy which has allowed even the Canadian hospitals to be scattered all over the country, instead of being concentrated in special localities. As a result, efficient control and inspection have been rendered exceedingly difficult and needless expense has been involved. He recalls that when the Ontario Government started to provide its splendid hospital, with a capacity of 1,040 beds, it offered to locate it at any place desired, thus affording a splendid opportunity to secure the concentration of hospitals in a definite area, with this most valuable primary hospital as a nucleus. The opportunity was let slip.

A map illustrates how Canadian hospitals have been scattered over England. Buxton is no less than 236 miles from Folkestone. Dr. Bruce recommends a concentration scheme and illustrates it also by a map. He says, however, it is impossible to make this ideal now because of the fear that present conditions do not justify the abolition of certain hospitals upon which large sums of money have been spent.

That there has been woeful laxity in weeding out medically unfit during the process of enlistment and training in Canada is demonstrated by ample evidence in Dr. Bruce's report. A Canadian pioneer draft arriving in England on June 29th,

1916, was found to have 57 unfits out of 254 of all ranks. Of 2,670 soldiers coming before medical boards from June 2nd to August 2nd, 1916, as only fit for permanent base duty, 1,340 ought never to have been at the front. Out of 1,452 discharges from the army during the same period, 816 had never got beyond England, that is 56 per cent. of the discharges had never been at the front.

Unfits in England are a great bother. They take the places on base duty of men who have been at the front and have a prior claim on any soft jobs available. Others clog up the hospitals, increasing the strain on the already overtaxed medical services. And further, Dr. Bruce points out, the question of pension arises. "Men who are discharged for a disability present on enlistment are not entitled to pension for that disability, but where pre-existing disability has been increased at least temporarily by active service, corresponding pension or gratuity must be allowed.

"In the last four months we have had over 1,000 recommended for permanent base duty from over age, with an average age of 49 to 50 years for each man. It is a common occurrence for the men, when questioned as to their given age when enlisted, to make a statement that they gave their true age as 54 or 55 years, as the case may be, and the medical officer said they would call him 41 or 42 years. In one case he was informed by the soldier that, on enlistment, the recruit on giving his proper age was told to run around the block, think over his age, and come back again.

"And again, during the last month alone (this from a report dated August 22nd) 120 boys were found in the ranks and put on permanent base duty. Their ages run as low as fourteen years."

Several pages are devoted to special cases of men who should never have enlisted. Among others, four cases from the 92nd Battalion are mentioned by name, two of them being discharged as permanently unfit and two to be put on base duty. "We have been informed, says the report, that these four men were paraded before a standing Medical Board in Canada by Capt. Maynard, and that they were recommended for discharge, but no action was taken, and they were brought to England."

One man was found with valvular disease of the heart, left hand partly cut off. He was enlisted at Edmonton.

Another Toronto man could not carry pack, suffers from vertigo, weight 105 pounds, chest when fully expanded 30½ inches; medical examiner, Capt. ———, Toronto.

Another case, discharged, congenital amblyopia, right eye vision defective, left eye vision lost. Medical examiner, Capt. ———, Toronto.

A photograph shows a boy enlisted at Pembroke, Ont., stripped, standing opposite a normal man. This boy was sixteen years of age, weight eighty pounds, had infantile paralysis, which left his legs in bad shape. He says he passed two medical boards in Canada, having been stripped on both occasions. He has never done any military duty, and has been in the hospital most of the four and one-half months he has been in England.

Another man was found to have been taken out of a tuberculosis sanitarium previous to embarkation.

Another man was blind in the right eye. His vision in the left is just about one-eighth what it should be. In other words, this man is fifteen-sixteenths blind.

Some units had as many as 25 per cent. unfits on arriving in England.

One of the over-age men was found to be 72 years old.

These are samples. The report contains fifteen pages of particulars of this kind, giving the names of the men, names of the medical examiners and full details.

Dr. Bruce recommends stringent changes in the methods of medical examination, in order that the great loss consequent upon the present system may be avoided.

Here is the wording of the headings of the twenty-three parts into which Dr. Bruce's report is divided:

1. Many soldiers are arriving in England from Canada medically unfit who should never have been enlisted.

2. The system of disposing of casualties from the front to Imperial hospitals in England, Wales, Scotland and Ireland is extremely unsatisfactory.

3. The present method of having Canadian hospitals scattered over such a large area is very objectionable.

4. There is unnecessary detention in hospitals. There has been no medical inspection by the Canadian Medical Service of Canadian soldiers in Imperial hospitals, and there has been no efficient medical inspection of Canadian hospitals, in consequence of which Canadian soldiers are retained in hospitals in Great Britain, many of whom should have been returned to duty, and others should have been returned to Canada, where they could have been more economically and efficiently treated. The lack of system permits of the aimless moving of patients from hospital to hospital.

5. The use by the Canadian Service of Voluntary Aid Hospitals is very undesirable, as they are inefficient, expensive and unsatisfactory.

6. The administration of the group of fifty-seven Voluntary Aid Hospitals under Shorncliffe Military Hospital by the Canadian Medical Service is unsatisfactory and expensive.

7. The present method of operating, jointly with the Red Cross, certain hospitals built and equipped by them is unsatisfactory. Such dual control is undesirable.

8. Impropriety of detailing Canadian Army Medical Corps personnel to Imperial hospitals and still retaining them on a Canadian pay-roll.

9. Unsatisfactory situation at Shorncliffe owing to our Canadian A.D.M.S. acting in a similar capacity over a large area for the Imperial authorities.

10. No attempt has been made to restrict surgical operations which produce no increased military efficiency.

11. The installation of an expensive plant at Ramsgate was inadvisable, as a large number of the cases treated there should be sent to Canada for treatment.

12. The establishment at Buxton of a special hospital for the treatment of rheumatics was ill-advised, as the majority of rheumatics will not be fit again for active service and could be better and more cheaply treated in Canada.

13. The present system of handling Canadian venereal patients is very strongly condemned.

14. The method of handling infectious diseases is most unsatisfactory.

15. Medical boards which regulate the classification of casualties are not available.

17. The exceedingly important question of pensions, which will involve the expenditure of large sums of money by Canada annually, has been neglected by the Canadian Medical Service.

18. Lack of co-ordination in the Canadian Medical Service between Canada, England and the front.

19. The medical personnel is not being used to the best advantage.

20. The policy of the department has been opposed to the use of experienced medical and surgical consulting specialists.

21. Discontent concerning promotions, especially in regard to regimental medical officers serving at the front.

22. The Canadian Army Medical Corps Training School in England has never been properly organized, although of the greatest importance to the Canadian Medical Service.

23. In the operation of the Medical Service sufficient regard has not been paid to economy in management.

WESTERN UNIVERSITY HOSPITAL UNIT

THOUGH the Western University of London, Ont., has had no organized body of men representing it in this war, till the formation of the Hospital Unit, already over fifty of their medical graduates are at the front. But this spring a committee of the faculty sent out a circular letter to all the remaining medical graduates asking them if they were desirous of going with the unit if it were formed. Twelve medical officers were needed to fill the positions. Seventy offered themselves.

Dr. Braithwaite, the president, and Dr. Edwin Seaborn were delegated at a meeting of the faculty to wait upon the Hon. Mr. Kemp (then acting Minister of Militia) to ask if there was a need of medical officers and hospital units. If the reply was in the affirmative, they were to offer a unit on behalf of the university.

This was done, and the offer was heartily accepted by the Government, with the request that the preparations for departure should be made as soon as possible.

The command of the unit was given Lieut.-Col. Edwin Seaborn, M.D. He was born in Quebec, and his mother was a French-Canadian. But his connection with the university is a long one, for his father was professor of natural science there, and a member of the Senate, and he himself took his medical course at the Western, graduating in 1895, and beginning to teach in the Medical School that same year. He has been in practice in London for 21 years. His wife is the charming daughter of the late Dr. Bucke.

Lieut.-Col. Seaborn is fortunate in having three brothers who are also doing their share for king and country. Lieut.-Col. Walter Seaborn is in command of the 210th (Moose Jaw) Battalion. Capt. George Seaborn is at present in France with the A.M.C., while Lieut. Vivian Seaborn is in the paymaster's office.

The establishment of the unit (which is a four hundred-bed hospital) is fourteen officers (twelve qualified medical men) one hundred and twenty N.C.O.'s and men, and twenty-seven nursing sisters.

Recruiting was brisk from the moment the office was opened, and the establishment might have been filled twice over. The men accepted are an exceedingly fine lot. There are a great many London men among them, but also a large proportion of men from the western Ontario district. They represent many phases of civil life.

The men were billeted and trained on the college campus or in the college buildings.

Their training consisted (as does that of all medical units), of squad, stretcher and company drill, and they were given lectures by the officers on anatomy, asepsis, fractures, hemorrhages, treatment of wounds, bandaging, infections, antiseptics, treatment of poisons, emergencies, as well as the care of the feet, and personal hygiene.

The citizens of London feel particularly interested in the Western University Hospital Unit, as being especially representative of both the town and the district. The local Red Cross

supplied them with all the medical, surgical and hospital supplies that they required over and above the Government supply. This gift cost about ten thousand dollars, and filled five hundred boxes.

A motor ambulance has also been given by the London Red Cross branch, the money having been raised by the tea-room committee.

Mrs. W. G. Nott, through the Red Cross, gave a cheque for one hundred dollars, to be used for special surgical instruments and supplies. Miss Balch, on behalf of the A.Y.P.A., of St. John the Evangelist Church, gave fifty dollars towards the purchase of band instruments.

The Meredith Dramatic Company gave a donation of two hundred dollars towards a motor car for the use of the unit. A good many donations were also made towards the special emergency fund of the unit.

This unit also took up the matter of insurance rates with the various companies that have agencies in London. This was to allow the men who enlisted to continue their insurance at pre-war rates, instead of paying an extra premium. The companies have responded very generously.

The unit left London on the 18th of August, and at present is in Shorncliffe for special training.

Everybody—in the prehistoric times before August, 1914—has watched the sham battles of the militia units during their twelve days' yearly training under canvas. Most of us have enjoyed the story of the captain who was marching his mounted men over a bridge when an irate lieutenant (belonging to the opposing forces) rose up from the shadows of the river bank in front and shouted:

"Hi, there! Stop! Don't you know we've just blown up the bridge?"

"You silly ass," says the captain, calmly continuing on his way, "can't you see we're swimming?"

But to-day there is less of pretence in the game. Even out here in the sunshine those imaginary wounded at the other end of the field suggest only too strongly those real wounded who have really waited for the stretcher-bearers in farther fields, when the stretchers have had a longer road to travel. When the

men, who are marching in close formation, change quickly to extended order, it takes very little effort of the imagination to realize that it is because they are under shell fire.

London people feel assured that the men of the Western University Hospital Unit will take their share of the Red Cross work satisfactorily.

KATHLEEN K. BOWKER.

MINNEWASKA SANITARIUM, GRAVENHURST

ONE of the problems which the Hospitals Commission has had to solve is that of providing for the care of the man in whom German gas, exposure in the trenches or training camps has developed tuberculosis. These men, no less than the man who has fallen, have offered their lives for their country, and their country's duty is to see that every means is used to give them back the health they have sacrificed for it. Their condition demands special treatment and isolation from other Military patients. In the absence of Military Hospitals for tubercular men, the Commission has arranged for their treatment in established institutions. One of these is the Minnewaska Sanitarium at Gravenhurst. There some sixty men have been placed during 1916 for treatment. Minnewaska Sanitarium is situated in a finely wooded ten-acre plot overlooking Gravenhurst Bay and lacks nothing in beauty of site or climatic condition. The Institution has been in successful operation for several years as a Private Hospital under the Superintendency of Mrs. Fournier, who is still in charge and whose experience has produced excellent results in the patient. The Institution is at present occupied almost entirely by soldiers, who began to be sent up in March last. Capt. Procter, M.D., and Lieut. Gillis, M.D., are in charge, both in a military and medical sense. It is hoped that the Hospitals Commission will ere long be able to erect a wing to the Sanitarium where vocational training may be given the patients.

THE BRAMSHOTT MILITARY HOSPITAL

THE Bramshott Military Hospital, erected in the summer of 1915 by the Imperial authorities, was officially taken over by the Canadian Army Medical Corps on October 2nd. The hospital, which is one of the most complete of the military hospitals in England, has accommodation for 700 patients. During the summer months some 350 extra beds were added in adjacent buildings for overseas wounded. The hospital has two operating theatres, an up-to-date X-ray room, a good pathological department and a well-stocked dispensary.

No. 9 Stationary Hospital, from Nova Scotia, with several attached officers under Lieut.-Col. R. C. McLeod, has staffed the hospital. The staff consists of Lieut.-Col. P. C. McLeod, of North Sydney, officer commanding; Major H. E. Kendall, Registrar of the Nova Scotia Medical Council, is senior physician; assistant physicians are Captains A. H. McKinnon, T. A. Lebbetter, J. F. Ellis and L. D. Densmore, all from Nova Scotia. The Surgical Division is in charge of Lieut.-Col. C. H. Gilmour, of Toronto, late of No. 2 General Hospital, France; assistant surgeons are Captains K. A. McCuish and J. A. McCourt, of Nova Scotia, and Captain Webb, of Scranton, Pa. The X-ray Department is in charge of Capt. J. I. O'Connell, of Newfoundland, and the pathologist is Captain A. R. Campbell, of Yarmouth.

BASE HOSPITAL TAKES FIRE PRECAUTIONS

SPECIAL precautions are to be taken to safeguard patients at the Base Hospital, Gerrard Street East, Toronto, against the danger of fire, and efforts are now being made to provide more than adequate fire protection in the form of additional fire escapes and gongs.

The buildings were, of course, inspected and passed before occupied by the military, and at present a fire picquet is on duty night and day, but it was felt while the existing arrangements might be adequate more could be done to ensure complete safety to all the patients. It is understood that steel fire escapes may

be placed on the front of the building in addition to the ones already erected in the rear. The building in the group known as the Burnside Building is at present without a fire escape. General Logie has received an intimation from Mayor Church that the city will co-operate in every way possible with this precautionary work.

It is understood that similar steps will be taken by the Soldiers' Aid Commission in regard to the Spadina Military Hospital and the College Street Convalescent Home.

ANOTHER CANADIAN CONVALESCENT HOME FOR OFFICERS AT DIEPPE, FRANCE

Not long ago another Canadian Convalescent Home for Officers was opened at Dieppe, France, and is doing splendid work under the supervision of a number of Toronto women. The Superintendent is Mrs. Christopher Robinson, and the Assistant Superintendent Mrs. Foster. The Sisters include the Misses Chadwick, Gault, Burnham, Murphy and others of Toronto. Mrs. (Dr.) J. F. W. Ross is Chairman of the Toronto Committee. The Hospital is certainly filling a most urgent want and is very popular.

THE DUCHESS OF CONNAUGHT CANADIAN HOSPITAL AT CLIVEDEN

LIEUT.-COL. (DR.) GORRELL definitely resigned in October the Superintendence of the Duchess of Connaught Canadian Hospital at Cliveden. It is understood that Lieut.-Col. Stewart, C.A.M.C., of Halifax, has been offered Dr. Gorrell's position, though we have not as yet learned whether he will accept.

A FIFTY thousand dollar building, to take care of soldiers invalided home with tuberculosis, is to be erected shortly by the London Health Association at Byron Sanatorium. This is at the request of the Military Hospitals Commission.

WAR HOSPITAL RUN ENTIRELY BY WOMEN

"THEY are even more than wonderful doctors and nurses; they are kind and gentle ladies." I do not think that the staff of the Military Hospital at Endell Street, from the doctor in charge or the chief surgeon down to the portress of the gate, have ever had a prettier or more deserved compliment than this, paid by a soldier grievously wounded in the Great Push, says a writer in *The London Daily Mail*.

Set in the very centre of London and surrounded by a maze of grey buildings with no green thing nearer than the vegetables at Covent Garden, and with the buzz and whirl of London traffic all around, the Endell Street Hospital has become one of the brightest havens in England. It has also proved the justification of women's long and insistent demands for high place in surgery and medicine, and has proved without doubt to all men engaged in the Medical Profession—and to the world outside that profession—that women doctors are equally successful with themselves in all branches of their calling, and not only with those ailments generally peculiar to women and children.

The only Military Hospital entirely staffed by women under the War Office, this Hospital is the outcome of the foresighted patriotism of the Women's Hospital Corps, founded during the first two weeks of the war by two of the leading women doctors in England. Both young women, they formed a little band of workers and appealed to their friends for funds. With a fine equipment of drugs, instruments and medical appliances, and all real necessities for a Hospital of about 130 beds, they arrived in Paris just at the time when the Germans were digging themselves in on the Aisne and when the wounded were pouring into Paris in appalling numbers.

For four months they remained in Paris and then, as the British moved farther north, the Women's Hospital Corps also moved their Hospital, this time to Boulogne. Placing their voluntary services at the disposal of the War Office they were finally quartered at the Endell Street Hospital, equipped by and run under the military authorities.

The Hospital consists of 17 wards with 573 beds in all, and the staff counts 15 doctors, including oculist, dental surgeon, and anesthetist; quartermaster, 84 women orderlies, 4 of sergeant rank; kitchen helpers, and a few men of the "R.A.M.C."

It is no secret that since July 1 the wounded have been coming in in greater numbers than before and that "mended" soldiers have to be evacuated at the rate of more than 100 a week. While several of the men who came in slightly wounded at the beginning of the month have already been discharged, there has been a sad proportion of seriously wounded who have needed all the fruits of the experience the doctors have gained during their two years' work. On several occasions during these last weeks the chief surgeon has been in the operating theatre for twelve hours on end, only ceasing her labors for a few minutes for necessary food.

The Hospital has no garden, but it has a great square courtyard into which the beds of the men are wheeled at the earliest possible moment. Part of the courtyard is covered in with a glass roof, and those soldiers requiring constant open-air treatment have a hut and a Japanese summer-house, and the Hospital would like another hut, too, if some sympathizers would give it. The courtyard is made as gay as possible by plants and flowers which women gardeners come every day to tend and also to arrange the flowers in the wards.

The men have gay sunshades over their beds and red and blue quilts left over from the Paris days. The idea is to get as much color in the wards as possible, and it is wonderful how the patients appreciate such relief. The laboratory and dispensary open on to the courtyard, also the men's dining room, and of course the offices. The recreation hall is ruled over by Miss Beatrice Harraden as librarian and Miss Bessie Hatton as organizing secretary for entertainments. It has a good supply of books, a fine grand piano with a tone quite equal to the ornamentation on the case, and that says a good deal! A stage at the end of the hall is hung with a Gobelin blue curtain bearing the monogram "W. H. C." and khaki grey back curtains; over all is the motto "Deeds, not words."

The quartermaster has all her departments organized with the experience that two years have given her. She serves 140

men in the dining room with meat, vegetables and milk pudding with amazing rapidity, twenty-five minutes seeing them all fed, out again, and ready for any amount of entertainment and noise which may be provided for them or that they can make for themselves.

Every day brings grateful visitors to the Hospital, officers who were tended in Paris as well as the men, and it is a rare case when a man on leave from the front does not spare a few minutes to the Hospital where he has been so "jolly well mended," as one man said.

No wonder that they recommend the Women's Hospital Corps when they get "out there." Said a very badly wounded man as his stretcher was carried into the courtyard from an ambulance the other day: "I asked to come here; they told me on the other side I'd be well looked to here."

QUEEN'S HOSPITAL TO MOVE FROM TREPORT

WORD has been received from Lieut.-Col. Etherington that Queen's Hospital will move from Treport to Etaples as soon as the weather becomes too cold to stay in tents. The quarters, consisting of huts, are ready for their immediate occupation. The Hospital has treated over four thousand patients since going to France.

SIR WILLIAM OSLER recently cabled his resignation from the Canadian Army Medical Service to Sir Robert Borden at Ottawa, as a mark of his sympathy with Surgeon-General Jones. Sir William was appointed soon after the war began Honorary Consulting Physician at Queen's Hospital, Shorncliffe. Since then he has been Honorary Adviser in connection with all Canadian Hospitals throughout the Old Country.

Canadian Hospitals

ST. ELIZABETH'S HOSPITAL AT FARNHAM, QUEBEC, BURNED

SIX adults and five children, at least, lost their lives in a fire which destroyed St. Elizabeth Hospital on October 25th.

The hospital was managed by the Grey Nuns and comprised two buildings, one devoted to accommodating sick and another to a school for children. About three hundred persons were in the two buildings when the fire broke out, the majority of whom were in the sleeping quarters on the third floor of the hospital building when the fire was discovered. The blaze had its origin in a defective chimney.

About 7.30 o'clock smoke was observed stealing through the building. Almost before the alarm could be given, and before assistance could reach the inmates, fiery tongues of flames were licking the coverings of the beds in the third storey. With almost incredible rapidity the fire spread, dense clouds of smoke rolling through the corridors. Fighting for breath, the terrified inmates, seeing a chance of escape, dashed for the fire escapes, many sufferers literally having to drag themselves along the floor. With admirable heroism officials and attendants of the institution worked frantically to aid their charges. Then came the horrifying revelation that the fire escapes would not work. Shrieks of terror rang out as, driven to desperation by the advancing glare, young and old jumped from the windows to fall crushed and maimed on the hard pavement beneath.

Keeping their heads amid the confusion, attendants guided their charges to every exit not yet cut off by the flames. Half unconscious, the victims were carried out into the grounds to be taken immediately in hand by the hundreds of helpers who had hurried to the spot.

It was at once realized that the fire-fighting equipment of the hospital and of Farnham was inadequate to combat the flames which were then licking every part of the doomed building and had already reached the adjoining buildings.

A hurry-up call was sent to St. Johns, Que., and immediately on receipt of the news the fire chief there loaded apparatus on a special train which rushed through the night at top speed. Arriving in Farnham about 9.30 o'clock the brigade went to work with a will, and after strenuous efforts succeeded in placing the fire under control.

St. Elizabeth Hospital was built about twenty years ago. It was originally of three stories and of brick. Recently a new four-storey wing was added. A church and college connected with the institution were burned down in 1911.

The hospital was entirely destroyed by the fire, only the ruins of the edifice being standing next morning. The loss is estimated at \$135,000, only \$35,000 insurance being carried on the premises.

NEEDS NEW WING

THE need for a new wing in which to accommodate the large number of cancer cases was emphasized at the forty-second annual meeting of the Toronto Hospital for Incurables, 130 Dunn Avenue. Sir Mortimer Clark presided, and among those invited were His Honor the Lieutenant-Governor, Sir John Hendrie, Lady and Miss Hendrie, Rev. J. W. Aikens, Dr. Edmund E. King, J. O. McCarthy, John Firstbrook and John MacDonald.

President Ambrose Kent gave a brief outline of the work of the hospital and showed how it had grown from the first house on Bathurst Street, at the instigation of Sir Mortimer Clark and the late Mr. Michie, until now over 234 cases were being cared for, seventy of whom were bedridden and twenty-two were cancer cases.

During the year the accommodation for this class of patients had been insufficient, for at one time thirty cases were being treated and there was only accommodation for twenty-four. It will cost about \$30,000 to erect a suitable wing in which to house fifty beds, or \$600 a bed. Dr. Edmund King stated that the daily upkeep was eighty-three and a half cents, which was comparatively low. During the year seventy-three deaths occurred, a number from old age and twenty-two through can-

cer. Last year the hospital had a balance of \$2,106.11, but this year it has decreased to \$1,143.41.

Rev. J. W. Aikins lauded the untiring efforts of the staff, and laid emphasis on the fact that Toronto's citizens were never in a better position to support charitable works in the giving of money. "Since Toronto has given up her sons to fight for the Empire, the giving of money has become but a small item," he declared.

DOUBLE ONTARIO HOSPITAL

AGENT-GENERAL REID cabled Premier Hearst on October 24th regarding a proposal to add five hundred to a thousand beds to the Ontario Hospital at Orpington. He thought possibly that if Ontario was only willing to supply five hundred, the balance could be supplied from the Dominion, but he hoped Ontario would give one thousand beds.

The total expense, as the cost of building has advanced fifteen per cent., is estimated at \$320,000.

The British authorities ask provision for four thousand additional beds in Canadian Hospitals in England.

\$51,000 RAISED BY THE UNIVERSITY HOSPITAL SUPPLY ASSOCIATION

THE statements recently issued by the University Hospital Supply Association are indeed encouraging. The Association was formed hastily on St. Patrick's Day, 1915, to equip No. 4 Canadian General Hospital, its membership being made up of the womenfolk belonging to the various faculties in the University. Each and every member worked tirelessly till September of last year, at which time it began to work for the Canadian Red Cross. The Treasurer, Mrs. F. N. G. Starr, has handed in subscriptions, etc., a little over fifty thousand dollars, with disbursements totalling \$45,510. The Convener of the Packing Committee reported that the packing between April, 1915, and October of this year, included 1,328 large cases of Hospital

Supplies, of which 667 went to No. 4 General Hospital; 654 to the Canadian Red Cross, with seven cases of socks to the Secours National. Mrs. Samuel Johnson, Convener of the Surgical Supply Committee, reported that a total of 1,146,575 pieces of surgical supplies, including pads, compresses and sponges, were made up to November 15th, 1915, and since that date a further number of 743,750. We heartily congratulate the Association upon their work.

RHEUMATIC PATIENTS TO BE TRANSFERRED FROM ENGLISH TO CANADIAN HOSPITALS

ARRANGEMENTS were recently made by the Military Hospitals Commission to treat in the Hospitals in Canada from 1,000 to 1,500 Canadian soldiers now under treatment in England for rheumatic trouble, and they will be brought to Canada as soon as the necessary accommodation and hospital equipment can be furnished. There are at present nearly 2,000 Canadian soldiers throughout England suffering from rheumatic and similar complaints, due to exposure in the trenches. A large percentage of these patients, after treatment in England in the British and Canadian Hospitals, are pronounced fit to return to the firing line, but experience has shown that renewed exposure in the trenches generally brings about a recurrence of the disease, and the military authorities have come to the conclusion that this method of looking after Canadian rheumatic cases has been unsatisfactory. Consequently after a careful investigation by a Medical Board, headed by Col. Herbert Bruce, of Toronto, it has been decided to bring these patients to Canada as soon as they are well enough to travel.

THE annual meeting of the supporters of the Kitchener Orphanage was held on October 30th, at which it was reported by the Matron, Miss Snyder, that 39 boys and 42 girls had been admitted to the institution during the year and that 114 orphans had been cared for. There was very little sickness and no deaths. The financial statement showed a substantial balance on hand.

DR. CLARKE WITHDRAWS FROM HOSPITAL WORK

THAT he may devote his time to his profession alone and to the social uplift organizations in which he had been interested for a number of years, Dr. Charles Kirk Clarke is about to retire as Superintendent of the Toronto General Hospital, a position which he has held for the past five years.

For over forty years Dean Clarke has been associated with hospitals, principally institutions for the treatment of the insane. In 1874, when he was seventeen years of age, he became Assistant Clinical Superintendent of the Toronto Lunatic Asylum, and a year after his graduation from the University of Toronto as a doctor of medicine he received the appointment of Assistant Medical Superintendent of the Hamilton Insane Asylum. From 1885 to 1905 he was Medical Superintendent of Rockwood Asylum. In 1905 he was appointed Medical Superintendent of Toronto Asylum, where he remained until he was asked to succeed Dr. J. N. E. Brown as Superintendent of the Toronto General Hospital.

In 1901 he was Royal Commissioner investigating the New Westminster Asylum, and in 1907 Royal Commissioner studying the methods of the treatment of the insane in Europe. In 1904 he was co-editor of the *American Journal of Insanity*.

Also he is considering his home. All of his family have enlisted and are overseas. The last to leave was his son, Sergeant-Major Clarke, of the 169th Battalion, who was a graduate of the Royal Military College, and a civil engineer by profession. Preferring to rise from the ranks and earn any promotion on his merits, Sergeant-Major Clarke enlisted as a private. A daughter enlisted in the University of Toronto Base Hospital as a nursing sister.

One of the departments which has been developed by Dean Clarke since he became Superintendent of the Hospital is the social service. By interesting public-spirited citizens he has been able to obtain funds to employ nurses to go into the homes of the poor who come into the hospital, to clothe them, their families, and aid them in other ways. By persistently pleading the needs of the feeble-minded he has placed many children and adults who were a menace to the community in different institutions and hospitals.

SPLENDID WORK OF THE BRITISH RED CROSS SOCIETY

It is the greatest source of satisfaction to all right-thinking Canadians to learn what the magnificent British Red Cross Society has been doing and is still doing in behalf of the sick and wounded throughout Europe.

The care of the wounded and sick of the British forces serving in France and Flanders falls under two main heads—their transport by motor ambulance and hospital train and the provision of hospitals.

Since September, 1914, the Joint Committee of the British Red Cross Society and the Order of St. John of Jerusalem have provided 1,100 motor ambulances serving the British army in France and Belgium, 60 with the French army, and 25 with the Belgians. The Committee have also established large repair shops at Boulogne, and between four and five hundred other vehicles, including lorries, repair wagons, touring cars and cycles. A personnel of over 1,500 persons is employed, of whom several have been mentioned in despatches, one having been awarded his D.C.M. A large number of women drivers employed at the Bases are members of the Red Cross Voluntary Aid Detachments and of the First Aid Nursing Yeomanry.

The following is a list of the Hospitals and Convalescent Homes at present established under the auspices of the Red Cross for sick and wounded soldiers in France:

St. John Brigade Hospital, 520 beds, Etaples; No. 1 Red Cross (Duchess of Westminster's), 150 beds, Le Touquet; No. 2 Red Cross, 250 beds, Rouen; No. 5 Red Cross (Lady Hadfield's), 100 beds, Wimereux; No. 6 Red Cross (Liverpool Merchants' Mobile), 252 beds, Etaples; No. 8 Red Cross (Baltic and Corn Exchange), 250 beds, Paris-Plage; No. 9 Red Cross (Millicent Sutherland Ambulance), 100 beds, Calais; No. 10 Red Cross (Lady Murray), 50 beds, Le Treport; Canadian Convalescent Home, 30 beds, Dieppe; Hospital Queen Alexandra (Friends' Ambulance Unit), 120 beds, Malo les Bains; No. 2 Anglo-Belgian (British Farmers'), 166 beds, Calais; Astoria Hospital (Lady Mitchelham), 200 beds, Paris; Barge Secours (F.A.U.), 26 beds, Bergues.

The following comprise the Hospitals now maintained under the Red Cross in Egypt:

No. 1 Red Cross Convalescent (Syrian), 35 beds, Alexandria; No. 3 Red Cross Convalescent (Lady Douglas, 42nd Division), 50 beds, Alexandria; No. 4 Red Cross Convalescent (Ross), 23 beds, Alexandria; No. 6 Red Cross Convalescent (Lady Howard De Walden), 150 beds, Alexandria; No. 7 Red Cross Convalescent (Sultan's Montazah Palace), 1,000 beds, Alexandria; No. 10 Red Cross Convalescent (Lindemann), 36 beds, Ibrahimieh; No. 11 Red Cross Convalescent (Old Residency, Mustapha), 17 beds, Alexandria; No. 12 Red Cross Convalescent (Officer's), 40 beds, Cairo; Red Cross Hospital, Saidieh (Giza), 520 beds, Cairo; Red Cross Convalescent Hospital, Walda Palace, Helouan, 100 beds, Cairo.

Two Hospitals, Nos. 8 and 9, were opened for nurses; No. 8 (Zizinia) is now closed, but No. 9 (Bulkley), containing 23 beds, at Alexandria, is doing admirable work.

Altogether four hospital trains have been placed at the disposal of the army through the Red Cross. Each train is designed to carry 450 men, but can carry 500 in times of pressure. They bring back the wounded swiftly and smoothly from behind the firing line to the coast. Removable beds are supported on brackets on either side of the carriages and are as comfortable as they can be made. Each train has an operating table, dispensary, kitchens, etc., and an expert staff. On occasion a train has been run into a siding and an urgent operation performed during the journey home. So far many thousands of men have travelled homewards in these trains from the battlefields of France and Flanders, among them His Majesty himself, after his severe accident while reviewing the troops. For instance, train known as No. 11 has carried in less than twelve months over twenty-six thousand patients and travelled as many miles.

Once again we take this opportunity of congratulating in the heartiest possible manner this splendid Society, which has done so much since the opening of this terrible war—the greatest crime of all centuries.

Hospital Items

WE take this opportunity of congratulating the Committee who had charge of the Queen Mary Hospital White Rose Day, which took place on September 7th last, on the result of their work. The net amount credited to the Queen Mary Hospital for Consumptive Children at Weston was \$12,470.06.

It is understood that the following compose the Board recently appointed to reorganize the matter of Canadian Hospitals now on Active Service: Col. H. A. Bruce, Toronto, Director; Capt. (Dr.) W. F. E. Wilson, St. Catharines, Second in Command; Col. Wallace Scott, Toronto, and Lieut.-Col. Walter McKeown, Toronto.

Personals

It was recently announced that Col. Murray MacLaren, of St. John, N.B., has been asked to take charge of Cliveden Hospital.

Mrs Isabella Holmes Keech, of St. Louis, Mo., made a donation of fifty thousand dollars to the Western Pennsylvania Hospital of Pittsburgh, Pa., in commemoration of her late husband, William H. Keech, a former prominent Pittsburgh businessman, who during his life was very much interested in charity.

Col. Geo. Nasmith, C.M.G., Toronto, and Col. Adami, of Montreal, have resigned from the Canadian Medical Service and returned to Canada. Both gentlemen have resumed their work, Col. Nasmith in the Toronto Health Laboratories, and Col. Adami at McGill University.

We extend hearty congratulations to our esteemed confrère, Capt. (Dr.) Harley Smith, of Toronto, now "doing his bit" at the Ontario Base Hospital, Orpington, on his recent promotion to the rank of major.

Book Reviews

Clinical Studies for Nurses for Second and Third Year Pupil Nurses. By CHARLOTTE A. AIKENS, formerly Superintendent of Columbia Hospital, Pittsburgh. Third edition. W. B. Saunders Company, Philadelphia and London.

In this book on Clinical Studies for Nurses Miss Aikens has in mind the securing of grading instruction for nurses—these studies being a sequel to her Primary Studies and designed to meet the needs of second and third-year pupil-nurses. This edition has been thoroughly revised. Additions have been made to various chapters and new illustrations introduced.

The author desires to emphasize the fact that this book is a compilation. But what has hitherto been scattered in various books and taught in lectures is here given in a systematic and concise form. Standard medical works and practising physicians who are teachers of medical students have been freely consulted. The comprehensiveness of the subjects treated, the practicability of suggestions offered, make the book a valuable adjunct to a nurse's or teacher's library.

The Expectant Mother. By SAMUEL WYLLIS BANDLER, M.D., Professor of Gynecology in the New York Post-Graduate Medical School and Hospital. Illustrated. Philadelphia and London: W. B. Saunders Company. 1916.

This book is full of useful information especially for the trained nurse. The author has endeavored to use simple language, but of necessity has employed many terms foreign to any but a medical vocabulary, and consequently the expectant mother would in many instances have difficulty in understanding them. But were she able to fully appreciate the many dangers of pregnancy and parturition, so well depicted by the author, she would be a brave woman who faced them, especially

for the first time, with the cheerful and hopeful mind so essential for her coming trial. The postpartum stage and care of the mother until the uterus has fully recovered and the directions for nursing and care of the child are good, and should be known to all expectant mothers. Twilight sleep has been well explained and reasons given for not using it. This is a very interesting little book.

W. J. W.

Care and Feeding of Infants and Children. A text-book for Trained Nurses. By WALTER RECUR RAMSAY, M.D., Associate Professor Diseases of Children, University of Minnesota, etc.

This little work shows a vast amount of work and considerable experience. It is not perfect, going too deeply into some subjects, and very sketchy in others. Some of the plates are excellent. The book is well printed, as are all J. B. Lippincott's, and may be found helpful in cases of emergency to the trained nurse.

The Control of Hunger in Health and Disease. By ANTON JULIUS CARLSON. Pp. 319. Illustrated with 38 plates. Chicago: The University of Chicago Press. September, 1916. Price, \$2.00 net, postage extra.

Those who were privileged to hear the address of the Professor of Physiology of the University of Chicago at the Academy of Medicine, Toronto, in October, upon hunger, appetite and gastric secretion, heard enough to create a desire to know more about the work he has done on the stomach.

The book contains a summary of the work carried out along these special lines in the Hull Physiological Laboratory of the university during the past four years. In the various chapters most of the biological and clinical literature of the subject is presented in condensed form, giving an excellent summary of our present knowledge.

There are some seventeen chapters with sub-headings in each. His method of study and deduction leads him to present

his conclusions at the end of each, a most admirable plan. One chapter is devoted to the action of bitter tonics (*a*) on the hunger mechanism, (*b*) on the secretion of gastric juice, (*c*) on food consumption, (*d*) on appetite in clinical cachexia. His results are interesting and should elicit further contributions on the subject from clinicians.

J. H. E.

The American Hospital Development. By EDWARD F. STEVENS.
Published by The Architectural Record Co., New York, 119
West Fortieth Street.

This beautiful brochure on calendered paper with lovely pictures of hospitals—American and European—is a reprint of two articles of Mr. Stevens which appeared a year ago in *The Architectural Record*.

The text describes the influence of European hospitals on American; and emphasizes the need of the special preparation of our American architects who attempt hospital designing in this sort of work—something insisted upon in German hospitals in particular.

The author shows some plans of the more recently constructed European hospitals and also plans of the newer American, particular emphasis being placed upon a number he himself designed.

The essayist, after a considerable apprenticeship with the veteran, Taylor, of Boston, boldly entered the special field of hospital architecture, and to specially equip himself for his chosen field has several times visited Europe and made careful and conscientious studies of the hospitals there.

Interesting studies of ward units are made, and some beautiful interiors are shown.



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NEW HOSPITAL APPLIANCES, ETC.

Artificial Limbs for Soldiers

THE Military Hospitals Commission has appointed a Committee on Orthopedics to consider the matter of artificial limbs for members of the Canadian Expeditionary Forces who need such appliances. The Committee is composed of the following: Dr. Clarence Starr, Toronto, President; Dr. W. E. Gallie, Toronto, and Lieut.-Col. McKenzie Forbes, M.D., Montreal. Dr. F. J. Shepherd, Montreal, one of the Medical members of the Commission, and Lieut.-Col. Thompson, M.D., the Medical Superintendent of the Commission, will be *ex-officio* members. As our readers are doubtless aware, the Commission some little time ago opened its own factory close to the Central Convalescent Hospital in Toronto.

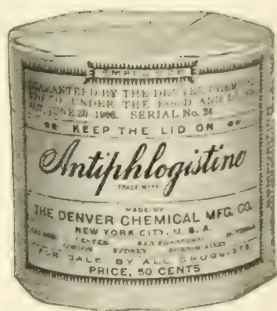
For Use in Institutions

IT must be most gratifying to the manufacturers of the Radiator Humidifying Pans that they have recently secured orders for the instalment of these Pans in such buildings as the Canadian Bank of Commerce, Imperial Bank of Canada, Dominion Bank of Canada, Bank of Montreal, Standard Bank of Canada, Bank of Toronto and many of its branches, the office of Dr. C. J. C. O. Hastings, Medical Officer of Health for the city of Toronto, Dr. John L. Davison, Dr. E. A. E. Howard, Sir Lyman Melvin-Jones, Imperial Life Insurance Co., Excelsior Life Insurance Co., University of Toronto and other buildings in Toronto and elsewhere.

There is no doubt that the use of Humidifying Pans properly moistens the air for breathing and can be the means of preventing a number of the common winter ailments, such as sore throat, headache, general malaise, etc. These Pans are installed on the radiator at the back, between the radiator and the wall, and are, therefore, out of sight. They vastly improve the atmosphere in any room, whether it be a private bedroom, a hospital ward or living room. They result in the air becoming infinitely more comfortable and also prevent the warping and cracking of woodwork, fine furniture, etc.

Pneumonia, Pleurisy, Bronchitis, Quinsy, Laryngitis, Etc.

increase with the coming of Winter and suggest, to the Physician of wide experience and success, the important role played in these diseases, of



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THIS preparation is an agreeable effervescent saline laxative and uric acid solvent, and has rapidly gained the favor of physicians generally. It is a combination of lithia and sodium phosphate with the laxative salts similar to those found in the most famous European bitter or purgative waters. The action of the salts held in solution in the "bitter waters" is too well known to demand specific elucidation, but their remedial value is considerably enhanced by the addition of lithia and sodium phosphate. Sal Hepatica can be employed as a laxative and eliminant of irritating toxins with safety and satisfaction in inflammatory conditions of the bowels, and is worthy of a prominent place in the diarrheas of infancy and childhood, and in "summer complaints," which arise from fermentative and putrefactive causes.

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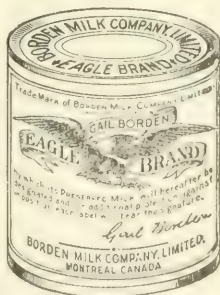
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Chronic Intestinal Indigestion

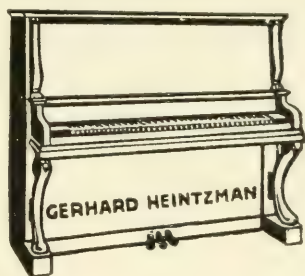
THIS chronic disorder frequently follows the acute form of indigestion, especially in children who are below par in general health and vitality. As in the acute variety, the condition is not one of positive bacterial invasion, but rather a negative state, in which there is a general inadequacy on the part of the normal intestinal flora to fulfil its function.

The child lapses into a state of chronic malnutrition; diarrhea alternates with constipation, the stools being white or grayish in color, lumpy in consistency, acid in reaction, rancid in odor, and containing curds and particles of undigested food.

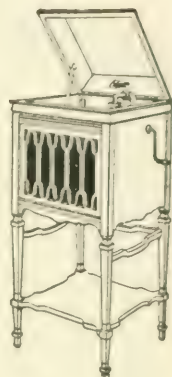
The patient should, if possible, be removed to the country, preferably to the seaside or the mountains, and given the advantages of a rigorous hygiené. The diet needs the most careful individual selection and adjustment in each case; but the general principle is that it should consist of concentrated, pre-digested food, such as beef peptonoids, egg albumen, whey, malted foods, etc. The bowel should be frequently irrigated, clear up to the colon, with tepid water, to which listerine has been added in the proportion of two ounces to the pint, but no astringents. Injections of olive oil and cacao butter are also useful to assist nutrition.

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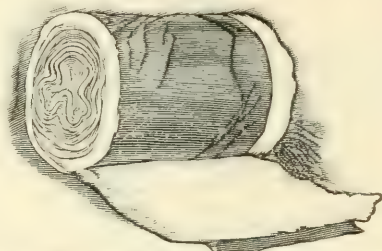
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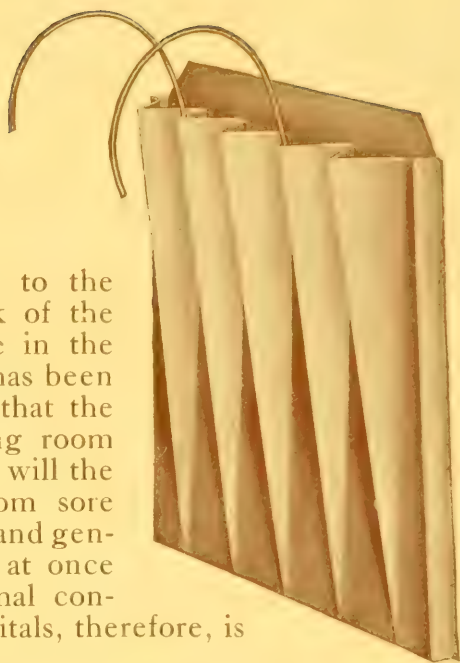
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